eHealth, Inc.
Form 10-Q
August 07, 2013

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

FORM 10-Q

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

For the quarterly period ended June 30, 2013

OR

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

For the transition period from to

001-33071

(Commission File Number)

EHEALTH, INC.

(Exact name of registrant as specified in its charter)

Delaware	56-2357876
(State or other jurisdiction of 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 31, 2013 was 18,415,995 shares.

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PART I

FINANCIAL INFORMATION

ITEM 1. FINANCIAL STATEMENTS

EHEALTH, INC.

CONDENSED CONSOLIDATED BALANCE SHEETS

(In thousands)

	December 31, 2012	June 30, 2013 (unaudited)
Assets		
Current assets:		
Cash and cash equivalents	$ 140,849	$ 89,713
Accounts receivable	4,468	5,334
Deferred income taxes	4,098	6,434
Prepaid expenses and other current assets	6,643	7,141
Total current assets	156,058	108,622
Property and equipment, net	6,185	9,482
Deferred income taxes	2,928	4,413
Other assets	8,123	6,257
Intangible assets, net	8,911	8,204
Goodwill	14,096	14,096
Total assets	$ 196,301	$ 151,074

Liabilities and stockholders' equity		
Current liabilities:		
Accounts payable	$ 6,123	$ 5,446
Accrued compensation and benefits	8,244	7,726
Accrued marketing expenses	3,941	3,367
Deferred revenue	926	1,546
Other current liabilities	1,575	2,613
Total current liabilities	20,809	20,698
Non-current liabilities	4,625	5,978
Stockholders' equity:		
Common stock	27	28
Additional paid-in capital	232,903	241,951
Treasury stock, at cost	(90,991)	(149,998)
Retained earnings	28,743	32,250
Accumulated other comprehensive income	185	167
Total stockholders' equity	170,867	124,398
Total liabilities and stockholders' equity	$ 196,301	$ 151,074

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

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EHEALTH, INC.

CONDENSED CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

(In thousands, except per share amounts, unaudited)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2013	2012	2013
Revenue				
Commission	$ 30,603	$ 34,942	$ 62,067	$ 73,193
Other	4,904	4,858	10,515	9,814
Total revenue	35,507	39,800	72,582	83,007
Operating costs and expenses:				
Cost of revenue	764	984	2,439	3,635
Marketing and advertising	12,167	13,761	25,154	28,596
Customer care and enrollment	6,358	7,812	12,329	14,978
Technology and content	5,033	7,727	10,515	14,468
General and administrative	6,590	7,132	13,194	14,651
Amortization of intangible assets	460	353	907	707
Total operating costs and expenses	31,372	37,769	64,538	77,035
Income from operations	4,135	2,031	8,044	5,972
Other income (expense), net	16	(21)	37	(46)
Income before provision for income taxes	4,151	2,010	8,081	5,926
Provision for income taxes	1,846	864	3,651	2,419
Net income	$ 2,305	$ 1,146	$ 4,430	$ 3,507
Net income per share:				
Basic	$ 0.12	$ 0.06	$ 0.23	$ 0.18
Diluted	$ 0.11	$ 0.06	$ 0.22	$ 0.17
Weighted-average number of shares used in per share amounts:				
Basic	19,624	18,946	19,580	19,754
Diluted	20,497	19,496	20,471	20,324
Comprehensive income:				
Net income	$ 2,305	$ 1,146	$ 4,430	$ 3,507
Foreign currency translation adjustment	-	(15)	(2)	(18)
Comprehensive income	$ 2,305	$ 1,131	$ 4,428	$ 3,489

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

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EHEALTH, INC.

CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

(In thousands, unaudited)

	Six Months Ended June 30,	
	2012	2013
Operating activities		
Net income	$ 4,430	$ 3,507
Adjustments to reconcile net income to net cash provided by operating activities:		
Deferred income taxes	(142)	(3,449)
Depreciation and amortization	1,114	1,390
Amortization of book-of-business consideration	1,418	2,548
Amortization of intangible assets	907	707
Stock-based compensation expense	2,987	3,416
Deferred rent	(17)	827
Changes in operating assets and liabilities:		
Accounts receivable	4,394	(866)
Prepaid expenses and other assets	(1,142)	(1,176)
Accounts payable	1,356	(1,541)
Accrued compensation and benefits	(1,572)	(530)
Accrued marketing expenses	(3,039)	(575)
Deferred revenue	88	887
Other current liabilities	1,943	952
Net cash provided by operating activities	12,725	6,097
Investing activities		
Purchases of property and equipment	(2,146)	(3,821)
Consideration paid in connection with book-of-business transfers	(6,243)	-
Net cash used in investing activities	(8,389)	(3,821)
Financing activities		
Net proceeds from exercise of common stock options	2,370	2,549
Cash used to net-share settle equity awards	(986)	(842)
Excess tax benefits from stock-based compensation	1,187	3,926
Repurchase of common stock	(8,441)	(59,007)

Principal payments in connection with capital leases	(18)	(26)
Net cash used in financing activities	(5,888)	(53,400)
Effect of exchange rate changes on cash and cash equivalents	-	(12)
Net decrease in cash and cash equivalents	(1,552)	(51,136)
Cash and cash equivalents at beginning of period	123,607	140,849
Cash and cash equivalents at end of period	$ 122,055	$ 89,713

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

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EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

Note 1 - Summary of Business and Significant Accounting Policies

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

Basis of Presentation—The accompanying condensed consolidated balance sheet as of June 30, 2013, the condensed consolidated statements of comprehensive income for the three and six months ended June 30, 2012 and 2013 and the condensed consolidated statements of cash flows for the six months ended June 30, 2012 and 2013, respectively, are unaudited. The condensed consolidated balance sheet data as of December 31, 2012 was derived from the audited consolidated financial statements included in our Annual Report on Form 10-K for the year ended December 31, 2012, which was filed with the Securities and Exchange Commission on March 13, 2013. 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, 2012, and include all adjustments necessary for the fair presentation of eHealth's statement of financial position as of June 30, 2013, its results of operations for the three and six months ended June 30, 2012 and 2013 and its cash flows for the six months ended June 30, 2012 and 2013. All adjustments are of a normal recurring nature. The property and equipment balance on the June 30, 2013 condensed consolidated balance sheet includes $0.9 million of leasehold improvements that are not included in the purchases of property and equipment balance in the condensed consolidated statement of cash flows for the six months ended June 30, 2013 because the amounts had not been paid as of June 30, 2013. The results for the three and six months ended June 30, 2013 are not necessarily indicative of the results to be expected for any subsequent period or for the fiscal year ending December 31, 2013.

Seasonality—The number of individual and family health insurance applications submitted through our ecommerce platform has generally increased in our first quarter compared to our fourth quarter and in our third quarter compared to our second quarter. Conversely, we have generally experienced a decline or flattening of individual and family submitted applications in our second quarter compared to our first quarter and in our fourth quarter compared to our third quarter. The majority of Medicare plans are sold in our fourth quarter during the Medicare annual enrollment period, when Medicare-eligible individuals are permitted to change their Medicare Advantage and Medicare Part D prescription drug coverage for the following year. As a result, we generate a significant amount of Medicare plan-related revenue in the fourth quarter of the year. Additionally, we recognize a majority of our renewal Medicare Advantage and Medicare Part D prescription drug plan commission revenue in the first quarter of each year as the majority of policies sold during the annual enrollment period typically renew on January 1 of each year.

Since a significant portion of our marketing and advertising expenses are driven by the number of health insurance applications submitted on our ecommerce platform, those expenses are influenced by these patterns. As a result, marketing and advertising expenses related to individual and family health insurance plans are highest in our first and third quarters, while marketing and advertising expenses related to Medicare-related plans are highest in our third and fourth quarters. Additionally, in preparation for the Medicare annual enrollment period, we begin ramping up our temporary customer care center staff during our second and third quarters and employ our temporary customer care center staff until the end of the Medicare annual enrollment period in December. Accordingly, our customer care center staffing costs are significantly higher in our third and fourth quarters compared to our first and second quarters.

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EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—CONTINUED

Recently Adopted Accounting Standards—Effective January 1, 2013, we adopted an accounting standards update with new guidance on the presentation of reclassifications from accumulated other comprehensive income to net income. This standard requires an entity to present reclassifications from accumulated other comprehensive income to net income either on the face of the condensed consolidated financial statements or in the notes to the condensed consolidated financial statements. In the six months ended June 30, 2013 we did not have any reclassifications from accumulated other comprehensive income to net income.

Note 2 – Cash, Cash Equivalents and Accounts Receivable

Cash and Cash Equivalents—As of December 31, 2012 and June 30, 2013, our cash equivalents consisted of money market accounts that invested in U.S. government-sponsored enterprise bonds and discount notes, U.S. government treasury bills and notes and repurchase agreements collateralized by U.S. government obligations. At December 31, 2012 and June 30, 2013, our cash equivalents carried no unrealized gains or losses and we did not realize any significant gains or losses on sales of cash equivalents during the three and six months ended June 30, 2012 and 2013.

As of December 31, 2012 and June 30, 2013, our cash and cash equivalent balances were invested as follows (in thousands):

	December 31, 2012	June 30, 2013
Cash	$ 27,484	$ 17,594
Money market funds	113,365	72,119
Total cash and cash equivalents	$ 140,849	$ 89,713

We used observable prices in active markets in determining the classification of our money market funds as Level 1 as of December 31, 2012 and June 30, 2013.

Accounts Receivable—As of December 31, 2012 and June 30, 2013, our accounts receivable consisted of the following (in thousands):

	December 31, 2012	June 30, 2013
Accounts receivable - from other revenues	$ 3,319	$ 1,552
Commissions receivable	1,149	3,782
Total accounts receivable	$ 4,468	$ 5,334

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EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—CONTINUED

Note 3 – Stockholders' Equity

Stock Plans—The following table summarizes activity under our 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, 2012 (1)	3,982
Additional shares authorized (2)	818
Restricted stock units granted	(561)
Options granted	(78)
Restricted stock units cancelled	17
Options cancelled	49
Shares available for grant June 30, 2013 (1)	4,227

(1) Shares available for grant do not include treasury stock shares that could also become available for grant if we determined to do so.

(2) On January 1, 2013, the number of shares authorized for issuance under the 2006 Equity Incentive Plan was automatically increased pursuant to the terms of the 2006 Equity Incentive Plan.

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

Number of Stock Options	Weighted Average Exercise	Weighted-Average Remaining Contractual Life (years)	Aggregate Intrinsic Value (1)

		Price		
Balance outstanding at December 31, 2012	2,956	$ 13.41	3.91	$ 41,642
Granted	78	$ 19.26		
Exercised	(694)	$ 3.67		
Cancelled	(49)	$ 18.23		
Balance outstanding at June 30, 2013	2,291	$ 16.46	4.39	$ 14,827
Vested and expected to vest at June 30, 2013	2,221	$ 16.42	4.34	$ 14,445
Exercisable at June 30, 2013	1,430	$ 15.97	3.62	$ 9,929

(1) The aggregate intrinsic value is calculated as the difference between eHealth's closing stock price as of December 31, 2012 and June 30, 2013 and the exercise price of in-the-money options as of those dates.

The total grant date fair value of stock options vested during the three and six months ended June 30, 2012 was $0.5 million and $1.4 million, respectively. The total grant date fair value of stock options vested during the three and six months ended June 30, 2013 was $0.7 million and $2.0 million, respectively.

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EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—CONTINUED

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

	Number Outstanding	Weighted-Average Remaining Contractual Life (years)	Aggregate Intrinsic Value (1)
Balance outstanding as of December 31, 2012	381	2.22	$ 10,464
Granted	561		
Vested	(163)		
Cancelled	(17)		
Balance outstanding as of June 30, 2013	762	2.62	$ 17,306

(1) The aggregate intrinsic value is calculated as eHealth's closing stock price as of December 31, 2012 and June 30, 2013 multiplied by the number of restricted stock units outstanding as of December 31, 2012 and June 30, 2013, 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 total grant date fair value of restricted stock units vested during the three and six months ended June 30, 2012 was $1.1 million and $3.7 million, respectively. The total grant date fair value of restricted stock units vested during the three and six months ended June 30, 2013 was $1.2 million and $3.2 million, respectively.

Stock Repurchase Programs—On September 10, 2012, we announced that our board of directors approved a stock repurchase program authorizing us to purchase up to $30 million of our common stock and on March 6, 2013, we announced that our board of directors increased the approved repurchase amount under this program to $60 million. Purchases under this program were made in the open market and complied with Rule 10b-18 under the Securities Exchange Act of 1934, as amended. The cost of the repurchased shares was funded from available working capital.

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

Stock repurchase activity under our stock repurchase programs during the six months ended June 30, 2013 is summarized as follows (dollars in thousands, except share and per share amounts):

	Total Number of Shares Repurchased	Average Price Paid per Share (2)	Amount of Repurchase
Cumulative balance at December 31, 2012 (1)	6,397,803	$ 14.22	$ 90,991
Repurchases of common stock during 2013	2,911,466	$ 20.27	59,007
Cumulative balance at June 30, 2013 (1)	9,309,269	$ 16.11	$ 149,998

(1) Cumulative balances at December 31, 2012 and June 30, 2013 consist of shares repurchased in connection with our stock repurchase program announced on September 10, 2012, as well as previous stock repurchase plans announced in 2011, 2010 and 2008.
(2) Average price paid per share includes commissions.

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EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—CONTINUED

In addition to the shares repurchased under our repurchase programs as of June 30, 2013, we have in treasury 206,435 shares that were previously surrendered by employees to satisfy tax withholdings due in connection with the vesting of certain restricted stock units. As of December 31, 2012 and June 30, 2013, we had a total of 6,556,303 million shares and 9,515,704 million 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, 2012 and 2013 was estimated using the following weighted average assumptions:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2013	2012	2013
Expected term	4.7 years	4.3 years	4.7 years	4.3 years
Expected volatility	44.4%	39.7%	44.4%	39.7%
Expected dividend yield	0%	0%	0%	0%
Risk-free interest rate	0.94%	0.62%	0.94%	0.62%
Weighted-average fair value	$ 6.40	$ 6.32	$ 6.40	$ 6.32

The following table summarizes stock-based compensation expense recorded during the three and six months ended June 30, 2012 and 2013 (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2013	2012	2013
Common stock options	$ 674	$ 656	$ 1,365	$ 1,448
Restricted stock units	688	1,126	1,622	1,968
Total stock-based compensation expense	$ 1,362	$ 1,782	$ 2,987	$ 3,416

The following table summarizes stock-based compensation expense by operating function for the three and six months ended June 30, 2012 and 2013 (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2013	2012	2013
Marketing and advertising	$ 362	$ 470	$ 602	$ 929
Customer care and enrollment	74	81	153	169
Technology and content	218	385	551	704
General and administrative	708	846	1,681	1,614
Total stock-based compensation expense	$ 1,362	$ 1,782	$ 2,987	$ 3,416

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EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—CONTINUED

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, 2012 and 2013 (in thousands, except effective tax rate):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2013	2012	2013
Income before provision for income taxes	$ 4,151	$ 2,010	$ 8,081	$ 5,926
Provision for income taxes	$ 1,846	$ 864	$ 3,651	$ 2,419
Effective tax rate	44.5%	43.0%	45.2%	40.8%

Our effective tax rate in the three and six months ended June 30, 2012 was higher than statutory federal and state tax rates due primarily to non-deductible lobbying expenses and tax shortfalls related to share-based payments. Our effective tax rate in the three and six months ended June 30, 2013 was higher than statutory federal and state tax rates due primarily to non-deductible lobbying expenses, partially offset by a tax benefit resulting from the recent extension of the federal research tax credit through December 31, 2013.

During the three and six months ended June 30, 2012, we utilized excess federal and state tax benefits related to share-based payments, which resulted in increases of $0.6 million and $1.2 million, respectively, in Additional Paid-In Capital in the condensed consolidated balance sheets. During the three and six months ended June 30, 2013, we utilized excess federal and state tax benefits related to share-based payments, which resulted in increases of $0.5

million and $3.9 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.

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EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—CONTINUED

Note 5 – Net Income Per Share

Basic net income per share is computed by dividing net income by the weighted-average number of common shares outstanding for the period (excluding shares subject to repurchase). Diluted net income per share is computed by dividing the net income for the period by the weighted average number of common and common equivalent shares outstanding during the period. Diluted net income per share is computed giving effect to all potential dilutive common stock equivalent shares, including options, restricted stock 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.

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

	Three Months Ended		Six Months Ended	
	June 30, 2012	2013	June 30, 2012	2013
Basic:				
Numerator:				
Net income allocated to common stock	$ 2,305	$ 1,146	$ 4,430	$ 3,507
Denominator:				
Weighted average number of common stock shares	19,624	19,532	20,118	21,019
Weighted average number of common stock shares repurchased	-	(586)	(538)	(1,265)
Net weighted average number of common stock shares outstanding	19,624	18,946	19,580	19,754
Net income per share—basic:	$ 0.12	$ 0.06	$ 0.23	$ 0.18
Diluted:				
Numerator:				
Net income allocated to common stock	$ 2,305	$ 1,146	$ 4,430	$ 3,507

Denominator:				
Net weighted average number of common stock shares outstanding	19,624	18,946	19,580	19,754
Weighted average number of options	789	445	774	453
Weighted average number of restricted stock units	84	105	117	117
Total common stock shares used in per share calculation	20,497	19,496	20,471	20,324
Net income per share—diluted:	$ 0.11	$ 0.06	$ 0.22	$ 0.17

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EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—CONTINUED

For each of the three- and six- month periods ended June 30, 2012 and 2013, 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. 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,	
	2012	2013	2012	2013
Common stock options	1,466	290	1,507	312
Restricted stock units	-	12	-	6
Total	1,466	302	1,507	318

Note 6 – Geographic Information and Significant Customers

Geographic Information—As of December 31, 2012 and June 30, 2013, our long-lived assets consisted primarily of property and equipment, goodwill and other indefinite-lived intangible assets and finite-lived intangible assets. Our long-lived assets are attributed to the geographic location in which they are located. Long-lived assets by geographical area were as follows (in thousands):

	As of December 31, 2012	As of June 30, 2013

United States	$ 37,037	$ 37,726
China	278	313
Total	$ 37,315	$ 38,039

Significant Customers—Substantially all revenue for the three and six months ended June 30, 2012 and 2013 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, 2012 and 2013 are presented in the table below:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2013	2012	2013
Humana	13%	17%	15%	20%
WellPoint (1)	15%	13%	13%	12%
UnitedHealthcare (2)	14%	11%	13%	11%

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

Commission revenue attributable to major medical individual and family health insurance plans was approximately 79% and 78% of our commission revenue in the three and six months ended June 30, 2012, respectively. Commission revenue attributable to major medical individual and family health insurance plans was approximately 75% and 70% of our commission revenue in the three and six months ended June 30, 2013, 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, accident and student insurance plan offerings.

As of December 31, 2012, four customers represented 25%, 22%, 14% and 11%, respectively, for a combined total of 72% of our $4.5 million outstanding accounts receivable balance. As of June 30, 2013, one customer represented 68% of our $5.3 million outstanding accounts receivable balance. No other customers represented 10% or more of our total accounts

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EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—CONTINUED

receivable at December 31, 2012 and June 30, 2013. We believe the potential for collection issues with any of our customers is minimal as of June 30, 2013. Accordingly, our estimate for uncollectible amounts at June 30, 2013 was not material.

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

In addition to historical information, this Quarterly Report on Form 10-Q contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934. These statements include, among other things, statements regarding our expectations relating to revenue (including commission revenue, lead referral revenue, advertising revenue and other revenue), sources of revenue, cost of revenue, the collectability of our accounts receivable and our estimate of accounts receivable as of June 30, 2013, profitability, operating expenses, marketing and advertising expenses, customer care and enrollment employees and expenses, technology and content expenses, general and administrative expenses; our future commission rate structure; our overall individual and family health insurance commission rate structure, the timing of our recognition of a majority of our first year Medicare Advantage and Medicare Part D prescription drug plan commission revenue, an increase in our commission revenue in absolute dollars in 2013 relative to 2012, the amount of fees we pay to marketing partners for consumer referrals that result in submitted health insurance applications, seasonal and absolute increases in our customer care and enrollment costs, increases in technology and content expenses, increases in general and administrative expenses, our estimate of the number of continuing members on all policies, our significant accounting policies, the sufficiency of our cash generated from operations and our current cash and cash equivalents, the comparability of member retention rates and the commissions that health insurance carriers pay in connection our sale of individual and family health insurance; the advantages of a long-standing provision of each state’s law relating to health insurance premiums; our intention to perform services for substantially all Medicare leads as a health insurance agent; the seasonality of our business and financial results; the timing and amount of our future lease obligations; the impact of health care reform laws on the health insurance industry and on our business; the timing of health care reform open enrollment periods and readiness therefore; our plans and expectations relating to our Medicare business and factors impacting its success; impact of medical loss ratio regulations and commission rate changes; our expectations and projections relating to membership and commission rates; the timing and source of our Medicare-related revenue; estimates relating to critical accounting policies and related impact on our financial statements; the sufficiency of our cash and cash equivalents; future capital requirements; our projections relating to future revenue growth and earnings per share; our future competitors; expansion into new business areas and additional geographic regions; our need for additional regulatory licenses and approvals; 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 2013, 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, Medicare-related, small business and ancillary health insurance plans. Our ecommerce technology also enables us to deliver consumers' health insurance applications electronically to health insurance carriers. As a result, we simplify and streamline the complex and traditionally paper-intensive health insurance sales and purchasing process.

We have invested heavily in technology and content related to our ecommerce platform. We have also invested significant time and resources in obtaining licenses to sell health insurance in all 50 states and the District of Columbia, developing diverse member acquisition programs, obtaining necessary regulatory approvals of our websites and establishing relationships and appointments with over 200 leading insurance carriers, enabling us to offer thousands of health insurance plans online. Our ecommerce platforms can be accessed directly through our website as well as through our network of marketing partners.

We generate revenue primarily from commissions we receive from health insurance carriers whose health insurance policies are purchased through our ecommerce platform. Commission revenue represented 86% of total revenue in the three and six months ended June 30, 2012 and represented 88% of total revenue in the three and six months ended June 30, 2013.

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The commission payments we receive for individual and family, small business and ancillary health insurance policies are typically a percentage of the premium on the health insurance policy that we sold and are typically made to us on a monthly basis for as long as the policy remains active with us.

We actively market the availability of Medicare-related health insurance plans through our online Medicare plan platforms www.eHealthMedicare.com and www.PlanPrescriber.com. Our Medicare plan platforms enable consumers to research and compare Medicare-related health insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. Commission payments we receive for Medicare Advantage and Medicare Part D prescription drug plans sold by us are typically fixed and are earned over a period of up to six years, or longer depending on the carrier arrangement, and are paid to us either monthly or annually. Medicare commissions we receive are included in commission revenue.

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

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

Many aspects of health care reform become effective in 2014. Health insurance carriers have been required as a part of health care reform to maintain medical loss ratios of eighty percent in their individual and family health insurance business since the beginning of 2011. The implementation of the medical loss ratio requirements by 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. The implementation of an eighty-five percent medical loss ratio requirement for Medicare Advantage plans is scheduled to be implemented in 2014, and it is unclear what impact that implementation will have on our commission rates, if any.

While aspects of health care reform may positively impact our business, the aggregate future impact of the implementation of health care reform on our business and financial results is uncertain. For instance, it is unclear how

our existing members will react to health care reform and whether they will seek or be forced to purchase new health insurance products once health insurance carriers implement new health insurance plans or change existing plans in response to health care reform requirements. Our ability to continue to act as a health insurance agent for our members who switch to a new health insurance product will be dependent upon a number of factors, including health insurance company practices, individual financial circumstances, our members' existing health insurance plans, the price of health insurance and our ability to expand our offering to include subsidy-eligible health insurance plans. In order to be eligible for a subsidy, qualified individuals must purchase subsidy-qualifying health plans through a government-run health insurance exchange. These qualified health plans are required to be purchased during an initial open enrollment period scheduled to begin in October 2013 and run through March 2014. While a large number of consumers may enter the market for individual health insurance in response to health care reform given the requirement that individuals maintain health insurance or face a tax penalty, it is unclear whether the tax penalty will have this intended effect, particularly if health insurance carriers significantly increase the cost of health insurance in response to health care reform. Moreover, we will face new competition in the form of government-run health insurance exchanges and our ability to act as a health insurance agent to health care reform subsidy-eligible individuals is dependent upon permission from state health insurance exchanges and upon health insurance companies to allow us to sell subsidy-eligible health insurance plans and to pay us commissions in connection

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with their sale. Permission from government-run health insurance exchanges will be conditioned on our satisfying a number of requirements relating to the display of information on our websites as well as new and comprehensive privacy and security requirements. Our ability to meet these and other significant requirements in a short time frame could present significant challenges for us. The implementation of open enrollment periods for the purchase of individual health insurance also presents challenges to our ability to enroll a significant number of individuals into health insurance over a limited period of time. The impact of health care reform on our health insurance carrier partners and their reaction is also unclear. For instance, health insurance carriers have the ability to unilaterally change their relationship with us, including the commission rates we receive for acting as a health insurance agent and may reduce the amount they pay us, alter the manner and geographic areas in which they permit us to sell their products and change our relationship with them in any number of ways. Given the disruption that the implementation of health care reform may have on the health insurance market, health care reform could in the aggregate have a material adverse effect on our business and results of operations.

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

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

In the past we also derived a significant amount of revenue from referral fees paid to us based on leads generated by our online platforms that are delivered and sold to third parties. In early 2012 we began directly servicing most of the Medicare leads we generated as a health insurance agent, while significantly reducing the number of Medicare leads we sold to third parties. As a result, our lead referral revenue declined significantly in 2013 compared to 2012. To the extent that we assist in the sale of Medicare-related insurance plans as a health insurance agent, we generate revenue from commissions we receive from health insurance carriers, rather than one-time referral fees we receive for the sale of Medicare leads.

Sources of Revenue

Commission Revenue

We generate revenue primarily from commissions we receive from health insurance carriers whose health insurance policies are purchased through us. Commissions for individual and family, small business and ancillary health insurance policies, such as stand-alone dental, life, student, vision, accident and short-term insurance plan offerings, have generally represented a percentage of the insurance premium and, to a much lesser extent, commission

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

Major medical individual and family health insurance plans do not include small business or Medicare-related health insurance plan offerings and do not include other ancillary products such as stand-alone dental, life, student, vision, accident and short-term insurance plan offerings. Our individual and family health insurance plan commission revenue has been adversely impacted due to the reduction in the commission rates that we are paid on new policies sold subsequent to the implementation of the medical loss ratio requirements beginning in 2011 as a result of health care reform legislation. Commission rate changes due to the implementation of the medical loss ratio requirements applied prospectively to applicable commissions earned on or after January 1, 2011 and the majority of the changes applied only to commissions earned on new individual and family plan members approved in 2011 and thereafter.

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We have increased our efforts to sell ancillary health insurance products, which include stand-alone dental, life, student, vision, accident and short-term insurance plan offerings, both in conjunction with the sale of an individual and family health insurance plan, as well as on a stand-alone basis,

We define a member as an individual covered by an insurance plan, including individual and family, Medicare-related, small business and ancillary plans, for which we are entitled to receive compensation. For the majority of individual and family plan members that were approved prior to the effective date of the commission rate changes, we are being paid commissions at the rates in effect prior to the changes. As a result, the adverse impact to our overall individual and family health insurance commission rate structure is being phased in as the number of members approved after the commission rate changes becomes a greater proportion of our individual and family plan membership. Although we believe our overall individual and family health insurance commission rate structure has stabilized from the adverse impact caused by the implementation of the medical loss ratio requirements, our actual future individual and family commission rate structure will depend on the total number of our individual and family plan members, the mix between individual and family plan members approved prior to the commission rate changes and those approved after the changes, any future changes to commission rates, including any changes that result from the implementation of major aspects of health care reform in 2014, and the mix of new approved members by state, health insurance carrier and type of health plan, among other factors. Additionally, other programs that health insurance carriers have supported, such as commission overrides and our sponsorship and advertising programs, have also been reduced as carriers look to reduce costs to comply with the new medical loss ratio requirements.

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

Under the federal Patient Protection and Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act, health insurance plans are required to be purchased by individuals, families and small businesses through government-run health insurance exchanges during an initial open enrollment period scheduled to begin in October 2013 and run through March 2014 in order for the individual, family or small business to receive subsidies from the government. Subsidy-eligible individuals, families and small businesses can thereafter change their qualified health plan only during annual enrollment periods scheduled to occur from October 15 through December 7

of each year thereafter, subject to states extending the period and exceptions for special enrollment periods for certain qualifying events. Moreover, some health insurance carriers and states have adopted, and others may adopt, open enrollment periods for the sale of health insurance outside of these exchanges. To the extent states allow us to market subsidy-eligible health plans and to the extent states or health insurance carriers adopt open enrollment periods for the sale of individual and family and small business health insurance in general, we will experience additional seasonality in both our sales volumes and expenses as a result of the enrollment period.

We actively market the availability of Medicare-related insurance plans through our online Medicare plan platforms, including (www.eHealthMedicare.com and www.PlanPrescriber.com). These platforms enable consumers to research and compare Medicare-related insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. We offer online application and telephonic enrollment capabilities for certain Medicare plans. To the extent that we assist in the sale of Medicare-related insurance plans as a health insurance agent, through either online applications or telephonically, we generate revenue from commissions we receive from health insurance carriers. The commission payments we receive for Medicare Supplement plans are typically a percentage of the premium on the policy that we sold and are paid to us on a monthly basis for as long as a policy remains active with us. For both Medicare Advantage and Medicare Part D prescription drug plans, we receive a fixed, annual commission from insurance carriers after the policy is approved by the carrier and either a fixed, monthly commission beginning with and subsequent to the second policy year for a Medicare Advantage policy or a fixed, annual commission beginning with and subsequent to the

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second policy year for a Medicare Part D prescription drug policy. Additionally, these commission rates may be higher in the first twelve months of a policy if the policy is the first Medicare-related policy issued to the member. We may earn commission revenue for both Medicare Advantage and Medicare Part D prescription drug plans typically for a period of up to six years, or longer depending on the carrier arrangement, provided that the policy remains active with us.

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

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

Commission revenue attributable to major medical individual and family health insurance plans was 79% and 78% of commission revenue in the three and six months ended June 30, 2012, respectively, and was 75% and 70% of commission revenue in the three and six months ended June 30, 2013, 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, 2013, compared to the three and six months ended June 30, 2012, was due primarily to an increase in commission revenue attributable to both ancillary health insurance plans, consisting primarily of dental, accident and vision insurance plan offerings, and Medicare-related insurance plans.

We expect commission revenue to increase in absolute dollars in 2013 compared to 2012, primarily as a result of an increase in Medicare-related commission revenue, and to a lesser extent, increases in both individual and family plan and ancillary plan commission revenues.

Other Revenue

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

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

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

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party, we recognize revenue when the amounts earned are fixed or determinable and collection is reasonably assured. Typically, this occurs through our receipt of a cash payment from the third party along with a detailed statement containing the data that is tracked by the third party.

Medicare Lead Referral. Our online Medicare plan platforms (www.eHealthMedicare.com and www.PlanPrescriber.com) enable consumers to research and compare Medicare-related insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. The Medicare-related revenue we have generated includes referral fees paid to us based on Medicare leads generated by our online platforms that are delivered and sold to third parties. Prior to 2012, the majority of our lead referral revenue was generated during the Medicare annual enrollment period, which occurs during the fourth quarter of the calendar year. In the second quarter of 2012, we began to perform services for substantially all Medicare leads ourselves as a health insurance agent, for which we are entitled to receive commissions. As a result, our Medicare lead referral revenue declined substantially. In the future, we intend to continue to perform services for substantially all Medicare leads ourselves as a health insurance agent.

We expect other revenue to decline in absolute dollars in 2013 compared to 2012 due primarily to a decrease in Medicare lead referral revenue as a result of our strategic decision to directly service most of the Medicare leads we generate as a health insurance agent, while significantly reducing the number of Medicare leads we sell to third parties. As a result of this decision, we expect Medicare-related commission revenue to continue to increase in 2013. We also expect the decline in Medicare lead referral revenue to be partially offset by an increase in online sponsorship and advertising revenue.

Member Acquisition

An important factor in our revenue growth is the growth of our member base. 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 and www.PlanPrescriber.com, either directly or through algorithmic natural search listings on Internet search engines and directories. For the three and six months ended June 30, 2012, applications submitted through us for individual and family health insurance from our direct channel constituted 47% and 45%, respectively, of all individual and family health insurance applications submitted on our website. For the three and six months ended June 30, 2013, applications submitted through us for individual and family health insurance from our direct channel constituted 49% and 48%, respectively, of all individual and family health insurance applications submitted on our website.

Marketing Partners. Our marketing partner member acquisition channel consists of consumers who access our websites through a network of affiliate partners and financial services and other companies. Growth in our marketing partner channel depends upon our expanding marketing programs with existing partners and adding new partners to our network. For the three and six months ended June 30, 2012, applications submitted through us for individual and family health insurance plans from our marketing partner member acquisition channel constituted approximately 31% and 32%, respectively, of all individual and family health insurance applications submitted on our website. For both the three and six months ended June 30, 2013, applications submitted through us for individual and family health insurance plans from our marketing partner member acquisition channel constituted approximately 32% of all individual and family health insurance applications submitted on our website.

Online Advertising. Our online advertising member acquisition channel consists of consumers who access our websites through paid keyword search advertising from search engines such as Google, Bing and Yahoo!, as well as various Internet marketing programs such as banner advertising and email marketing. For the three and six months ended June 30, 2012, applications submitted through us for individual and family health insurance plans from our online advertising channel constituted approximately 22% and 23%, respectively, of all individual and family health insurance applications submitted on our website. For the three and six months ended June 30, 2013, applications submitted through us for individual and family health insurance plans from our online advertising channel constituted approximately 19% and 20%, respectively, of all individual and family health insurance applications submitted on our website.

In addition to our marketing channels, we have acquired Medicare members through transactions with a broker partner. We have entered into several agreements, whereby the partner has transferred certain of its existing Medicare plan members

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to us as the broker of record on the underlying policies. The first of these transferred books-of-business occurred in November 2010 and the most recent in June 2012.

Operating Costs and Expenses

Cost of Revenue

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

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

We expect cost of revenue to increase in absolute dollars in 2013 compared to 2012 due to an increase in 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.

Marketing and Advertising

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

Our marketing partner channel expenses consist primarily of fees paid to marketing partners with which we have a relationship. We compensate a significant number of our marketing partners by paying a fee each time a consumer referral from a partner results in a submitted health insurance application, regardless of whether the consumer's application is approved by the health insurance carrier. Many of our marketing partners have tiered arrangements in which the amount of the fee increases as the volume of submitted applications we receive from the marketing partner increases over a particular period. We recognize these expenditures in the period when a marketing partner's referral results in the submission of a health insurance application. The number of individual and family health insurance applications submitted through our ecommerce platform has generally increased in our first quarter compared to our fourth quarter and in our third quarter compared to our second quarter. Conversely, we have generally experienced a decline or flattening in individual and family submitted applications in our second quarter compared to our first quarter and in our fourth quarter compared to our third quarter. The impact the newly implemented open enrollment period for the purchase of major medical health insurance plans will have on our member acquisition channels is unclear, although we expect that the seasonal patterns for individual and family plan submitted applications will be impacted. The next open enrollment period is scheduled to begin in October 2013 and run through March 2014, and then is scheduled to occur within the fourth quarter of each calendar year starting in 2014. We also expect total marketing expenses will increase to some extent during the open enrollment period as consumers switch to subsidy-eligible policies.

The majority of Medicare plans are sold in our fourth quarter during the Medicare annual enrollment period, when Medicare-eligible individuals are permitted to change their Medicare Advantage and Medicare Part D prescription drug coverage for the following year. Since a significant portion of our marketing and advertising expenses are driven by the number of health insurance applications submitted on our website, those expenses are influenced by these patterns. In addition, because the total volume of submitted applications that we receive from our marketing partners is largely outside of our control, particularly during any short-term period, and because of our tiered marketing partner arrangements, we could incur expenses in excess of, or below, the amounts we had planned in periods of rapid change in the volume of submitted applications from marketing partner referrals. An unanticipated increase in submitted applications resulting from marketing partner referrals could cause our net income to be lower than our expectation, since the revenue to be derived from submitted applications that are approved by health insurance carriers will not be recognized until future periods.

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Paid keyword search advertising on search engines represents the majority of expenses in our online advertising channel. We incur expenses associated with search engine advertising in the period in which the consumer clicks on the advertisement. Similar to our marketing partner channel, expenses in our online advertising channel will increase or decrease in relation to any increase or decrease in consumers referred to our website as a result of search engine advertising. For example, due to the substantial increase in the number of consumers referred to our website from paid keyword search advertising during the Medicare annual enrollment period in the fourth quarter of 2012, we experienced a significant increase in online advertising expenses during the fourth quarter of 2012 compared to the other quarters of 2012. We also increased our discretionary spending for Medicare plan-related online advertising in the third and fourth quarters of 2012, compared to first and second quarters, in conjunction with the Medicare annual enrollment period in the fourth quarter of 2012. Because the majority of our Medicare plan-related revenue is not generated until the fourth quarter, our discretionary online advertising expenses had a negative impact on our profitability during the third quarter of 2012. These seasonal patterns also occurred in 2011 and we expect them to occur again in 2013.

We expect our marketing and advertising expenses to increase in absolute dollars in 2013 compared to 2012 due primarily to an increase in our Medicare-related online marketing and advertising expenditures during 2013, including paid keyword search advertising. We also expect our marketing and advertising expenses to decline as a percentage of total revenue in 2013 compared to 2012 as the growth rate in total revenue is expected to be higher than the growth rate in marketing and advertising expenses.

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. Beginning in the second quarters of 2012 and 2013, we hired, trained and obtained health insurance licenses and health insurance carrier appointments for additional employees in our customer care centers to service the increase in the volume of Medicare leads we received in the fourth quarter of 2012 and that we expect to receive in the fourth quarter of 2013 as a result of the Medicare annual enrollment period. Many of these additional customer care center employees are temporary and their employment terminates at or near the conclusion of the Medicare annual enrollment period in December. As a result of our temporary customer care center staffing requirements, we expect our customer care and enrollment costs to be higher in the third and fourth quarters of each year compared to the first and second quarters. Because the majority of our Medicare plan-related revenue is not generated until the fourth quarter, our temporary customer care center staffing costs incurred in the third quarter has had a significant negative impact on our profitability during that quarter. We expect these seasonal trends to continue in 2013.

We expect customer care and enrollment expenses to increase in absolute dollars in 2013 compared to 2012 as a result of additional personnel we have hired and expect to hire to service the expected increase in the volume of Medicare demand in 2013 and due to an increase in expenditures to further develop our Medicare plan sales capabilities.

Technology and Content

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

In order for us to offer and sell subsidy-eligible health insurance plans on our websites, we are required to meet certain conditions, such as compliance with standards for display of health plan and related information; providing consumers the ability to view all subsidy-eligible plans offered on the state's exchange; displaying all subsidy-eligible health plan data on the state's exchange; and providing a mechanism for consumers to withdraw from the application process to the state exchange. We are increasing our technology and content spending throughout 2013 in order to increase functionality to meet the conditions required to offer and sell subsidy-eligible health insurance plans and to enhance the user experience.

We expect technology and content expenses to increase in absolute dollars and as a percentage of total revenue in 2013 compared to 2012 as a result of an increase in labor and personnel costs in our product management and engineering departments as we increase our investment in our technology platform to further enhance the user experience, increase functionality and meet the requirements to offer and sell subsidy-eligible health insurance plans.

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General and Administrative

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

We expect our general and administrative expenses to increase in absolute dollars in 2013 compared to 2012 as we add infrastructure to support company growth.

Summary of Selected Metrics

The following table shows certain selected quarterly metrics for the three months ended June 30, 2012 and 2013 and as of June 30, 2012 and 2013:

Key Metrics:	Three Months Ended June 30, 2012	Three Months Ended June 30, 2013
Operating cash flows (1)	$ 7,632,000	$ 6,635,000
IFP submitted applications (2)	103,400	110,600
IFP approved members (3)	87,900	100,700
Total approved members (4)	148,500	190,400
Commission revenue (5)	$ 30,603,000	$ 34,942,000
Commission revenue per estimated member for the period (6)	$ 35.47	$ 32.58
	As of June 30, 2012	As of June 30, 2013
IFP estimated membership (7)	684,000	748,000
Medicare estimated membership (8)	42,900	80,400
Other estimated membership (9)	150,000	263,000
Total estimated membership (10)	876,900	1,091,400

Other Metrics:	Three Months Ended June 30, 2012	Three Months Ended June 30, 2013
Source of IFP submitted applications (as a percentage of total IFP applications for the period):		
Direct (11)	47%	49%
Marketing partners (12)	31%	32%
Online advertising (13)	22%	19%
Total	100%	100%

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Notes:

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

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

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

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

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

- For small business health insurance policies, we estimate the number of members using the number of initial members at the time the group is approved, and we update this number for changes in membership if such

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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.

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

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

Critical Accounting Policies and Estimates

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

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

" Revenue Recognition;
" Stock-Based Compensation;

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

During the three and six months ended June 30, 2013, there were no significant changes to our critical accounting policies and estimates. Please refer to Management's Discussion and Analysis of Financial Condition and Results of Operations contained in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2012, for a complete discussion of our critical accounting policies and estimates.

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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, 2012 and 2013 (dollars in thousands):

	Three Months Ended June 30,						Six Months Ended June 30,					
	2012			2013			2012			2013		
Revenue:												
Commission	$ 30,603	86	%	$ 34,942	88	%	$ 62,067	86	%	$ 73,193	88	%
Other	4,904	14		4,858	12		10,515	14		9,814	12	
Total revenue	35,507	100		39,800	100		72,582	100		83,007	100	
Operating costs and expenses:												
Cost of revenue	764	2		984	2		2,439	3		3,635	4	
Marketing and advertising	12,167	34		13,761	35		25,154	35		28,596	34	
Customer care and enrollment	6,358	18		7,812	20		12,329	17		14,978	18	
Technology and content	5,033	14		7,727	19		10,515	14		14,468	17	
General and administrative	6,590	19		7,132	18		13,194	18		14,651	18	
Amortization of intangible assets	460	1		353	1		907	1		707	1	
Total operating costs and expenses	31,372	88		37,769	95		64,538	89		77,035	93	
Income from operations	4,135	12		2,031	5		8,044	11		5,972	7	
Interest and other income (expense), net	16	0		(21)	(0)		37	0		(46)	(0)	
Income before provision for income taxes	4,151	12		2,010	5		8,081	11		5,926	7	
Provision for income taxes	1,846	5		864	2		3,651	5		2,419	3	
Net income	$ 2,305	6	%	$ 1,146	3	%	$ 4,430	6	%	$ 3,507	4	%

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2013	2012	2013
Marketing and advertising	$ 362	$ 470	$ 602	$ 929
Customer care and enrollment	74	81	153	169
Technology and content	218	385	551	704
General and administrative	708	846	1,681	1,614
Total stock-based compensation expense	$ 1,362	$ 1,782	$ 2,987	$ 3,416

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Three and Six Months Ended June 30, 2012 and 2013

Revenue

The following table presents our commission, other revenue and total revenue for the three and six months ended June 30, 2012 and 2013 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2012	2013	$	%	2012	2013	$	%
Commission	$ 30,603	$ 34,942	$ 4,339	14%	$ 62,067	$ 73,193	$ 11,126	18%
Percentage of total revenue	86%	88%			86%	88%		
Other	$ 4,904	$ 4,858	$ (46)	(1%)	$ 10,515	$ 9,814	$ (701)	(7%)
Percentage of total revenue	14%	12%			14%	12%		
Total revenue	$ 35,507	$ 39,800	$ 4,293	12%	$ 72,582	$ 83,007	$ 10,425	14%

Three Months Ended June 30, 2012 and 2013—Commission revenue increased in the three months ended June 30, 2013, compared to the three months ended June 30, 2012, due primarily to a $1.9 million increase in commission revenue related to individual and family plans, including commission overrides. Additionally, commission revenue related to ancillary health insurance products, consisting primarily of dental, accident and vision insurance plan offerings, increased $1.5 million and Medicare-related commission revenue increased $1.0 million. Medicare-related commission revenues increased due primarily to an increase in renewals of Medicare plans we sold in prior years. Additionally, Medicare-related commission revenues increased due to an increase in the number of Medicare plans we sold.

Other revenue decreased in the three months ended June 30, 2013, compared to the three months ended June 30, 2012, due primarily to a decrease in Medicare-related health insurance product lead referral revenue. The decrease in lead referral revenue was the result of our strategic decision to reduce the number of Medicare leads sold to third parties and to instead act as a health insurance agent to those leads. As health insurance agent, we are entitled to receive on-going commission revenue related to the sale of a health insurance policy, compared to a one-time referral fee for the sale of a lead. The decrease in Medicare lead revenue was partially offset by an increase in online sponsorship and advertising revenue.

Six Months Ended June 30, 2012 and 2013—Commission revenue increased in the six months ended June 30, 2013, compared to the six months ended June 30, 2012, due primarily to a $5.3 million increase in Medicare-related commission revenue, which was driven primarily by Medicare plan renewals, for which the first quarter is the highest volume quarter of each year. Additionally, Medicare-related commission revenues increased due to an increase in the number of Medicare plans we sold. Commission revenue related to individual and family plans, including commission overrides, increased $3.1 million and commission revenue related to ancillary health insurance products, consisting primarily of dental, accident and vision insurance plan offerings, increased $2.7 million.

Other revenue decreased in the six months ended June 30, 2013, compared to the six months ended June 30, 2012, due primarily to a decrease in Medicare-related health insurance product lead referral revenue, partially offset by an increase in online sponsorship and advertising revenue.

Operating Costs and Expenses

Cost of Revenue

The following table presents our cost of revenue for the three and six months ended June 30, 2012 and 2013 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2012	2013	$	%	2012	2013	$	%
Cost of revenue	$ 764	$ 984	$ 220	29%	$ 2,439	$ 3,635	$ 1,196	49%
Percentage of total revenue	2%	2%			3%	4%		

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Three Months Ended June 30, 2012 and 2013—Cost of revenue increased in the three months ended June 30, 2013, compared to the three months ended June 30, 2012, due primarily to an increase in amortization expense associated with consideration we paid in connection with several book-of-business transactions in which we acquired broker of record status on a number of Medicare health insurance plans. The amount of book-of-business consideration we amortize to cost of revenue each quarter is proportional to the amount of commission revenue we recognize on the underlying policies each quarter.

Six Months Ended June 30, 2012 and 2013—Cost of revenue increased in the six months ended June 30, 2013, compared to the six months ended June 30, 2012, due primarily to an increase in amortization expense associated with consideration we paid in connection with several book-of-business transactions in which we acquired broker of record status on a number of Medicare health insurance plans. The amount of book-of-business consideration we amortize to cost of revenue each period is proportional to the amount of commission revenue we recognize on the underlying policies each period.

Marketing and Advertising

The following table presents our marketing and advertising expenses for the three and six months ended June 30, 2012 and 2013 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2012	2013	$	%	2012	2013	$	%
Marketing and advertising	$ 12,167	$ 13,761	$ 1,594	13%	$ 25,154	$ 28,596	$ 3,442	14%
Percentage of total revenue	34%	35%			35%	34%		

Three Months Ended June 30, 2012 and 2013—Marketing and advertising expenses increased in the three months ended June 30, 2013 compared to the three months ended June 30, 2012, due primarily to an increase of $1.4 million in advertising expenses, including fees we pay to marketing partners for referrals that result in the submission of a health insurance application on our website, direct online advertising costs and paid keyword search advertising costs on Internet search engines. Additionally, compensation, benefits, stock-based compensation and other personnel costs increased $0.2 million as a result of an increase in marketing and advertising personnel.

Six Months Ended June 30, 2012 and 2013—Marketing and advertising expenses increased in the six months ended June 30, 2013 compared to the six months ended June 30, 2012, due primarily to an increase of $2.6 million in advertising expenses, including fees we pay to marketing partners for referrals that result in the submission of a health insurance application on our website, direct online advertising costs and paid keyword search advertising costs on Internet search engines. Additionally, compensation, benefits, stock-based compensation and other personnel costs increased

$0.8 million as a result of an increase in marketing and advertising personnel.

Customer Care and Enrollment

The following table presents our customer care and enrollment expenses for the three and six months ended June 30, 2012 and 2013 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2012	2013	$	%	2012	2013	$	%
Customer care and enrollment	$ 6,358	$ 7,812	$ 1,454	23%	$ 12,329	$ 14,978	$ 2,649	21%
Percentage of total revenue	18%	20%			17%	18%		

Three Months Ended June 30, 2012 and 2013—Customer care and enrollment expenses increased in the three months ended June 30, 2013 compared to the three months ended June 30, 2012, due primarily to additional customer care center

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personnel hired to service the increase in volume of Medicare leads serviced directly by us as a health insurance agent. As a result, compensation, benefits, stock-based compensation and other personnel costs increased $1.2 million and insurance licensing costs increased $0.1 million.

Six Months Ended June 30, 2012 and 2013—Customer care and enrollment expenses increased in the six months ended June 30, 2013 compared to the six months ended June 30, 2012, due primarily to additional customer care center personnel hired to service the increase in volume of Medicare leads serviced directly by us as a health insurance agent. As a result, compensation, benefits, stock-based compensation and other personnel costs increased $2.1 million and insurance licensing costs increased $0.1 million.

Technology and Content

The following table presents our technology and content expenses for the three and six months ended June 30, 2012 and 2013 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2012	2013	$	%	2012	2013	$	%
Technology and content	$ 5,033	$ 7,727	$ 2,694	54%	$ 10,515	$ 14,468	$ 3,953	38%
Percentage of total revenue	14%	19%			14%	17%		

Three Months Ended June 30, 2012 and 2013—Technology and content expenses increased in the three months ended June 30, 2013 compared to the three months ended June 30, 2012, primarily due to an increase of $2.2 million in compensation, benefits, stock-based compensation and other personnel costs as a result of an increase in technology and content personnel. Additionally, equipment maintenance costs increased $0.2 million.

Six Months Ended June 30, 2012 and 2013—Technology and content expenses increased in the six months ended June 30, 2013 compared to the six months ended June 30, 2012, primarily due to an increase of $3.6 million in compensation, benefits, stock-based compensation and other personnel costs as a result of an increase in technology and content personnel. Additionally, equipment maintenance costs increased $0.3 million.

General and Administrative

The following table presents our general and administrative expenses for the three and six months ended June 30, 2012 and 2013 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2012	2013	$	%	2012	2013	$	%
General and administrative	$ 6,590	$ 7,132	$ 542	8%	$ 13,194	$ 14,651	$ 1,457	11%
Percentage of total revenue	19%	18%			18%	18%		

Three Months Ended June 30, 2012 and 2013—General and administrative expenses increased in the three months ended June 30, 2013 compared to the three months ended June 30, 2012, due primarily to an increase of $0.4 million in compensation, benefits, stock-based compensation and other personnel costs as a result of an increase in general and administrative personnel as we add infrastructure to support company growth.

Six Months Ended June 30, 2012 and 2013—General and administrative expenses increased in the six months ended June 30, 2013 compared to the six months ended June 30, 2012, due primarily to an increase of $1.2 million in compensation, benefits, stock-based compensation and other personnel costs as a result of an increase in general and administrative personnel as we add infrastructure to support company growth.

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Amortization of Intangible Assets

The following table presents our amortization of intangible assets for the three and six months ended June 30, 2012 and 2013 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2012	2013	$	%	2012	2013	$	%
Amortization of intangible assets	$ 460	$ 353	$ (107)	(23%)	$ 907	$ 707	$ (200)	(22%)
Percentage of total revenue	1%	1%			1%	1%		

Three and Six Months Ended June 30, 2012 and 2013—Amortization expense related to intangible assets purchased through our acquisition of PlanPrescriber decreased in the three and six months ended June 30, 2013 compared to the three and six months ended June 30, 2012, respectively, as certain intangible assets were fully amortized during 2012.

Other Income (Expense), Net

The following table presents our other income (expense), net, for the three and six months ended June 30, 2012 and 2013 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2012	2013	$	%	2012	2013	$	%
Other income (expense), net	$ 16	$ (21)	$ (37)	(231%)	$ 37	$ (46)	$ (83)	(224%)
Percentage of total revenue	0%	(0%)			0%	(0%)		

Three and Six Months Ended June 30, 2012 and 2013—Interest earned on our invested cash more than offset administrative bank fees, investment management fees and interest expense on our capital leases in the three and six

months ended June 30, 2012. Administrative bank fees, management fees and interest expense on our capital lease obligations more than offset interest earned on our invested cash in the three and six months ended June 30, 2013.

Provision for Income Taxes

The following table presents our provision for income taxes for the three and six months ended June 30, 2012 and 2013 and the dollar changes from the prior year periods (dollars in thousands):

	Three Months Ended June 30,			Six Months Ended June 30,		
	2012	2013	Change $	2012	2013	Change $
Provision for income taxes	$ 1,846	$ 864	$ (982)	$ 3,651	$ 2,419	$ (1,232)
Percentage of total revenue	5%	2%		5%	3%	

Three Months Ended June 30, 2012 and 2013—In the three months ended June 30, 2012 and 2013, we recorded a provision for income taxes representing effective tax rates of 44.5% and 43.0%, respectively. Our effective tax rate for the three months ended June 30, 2012 was higher than statutory federal and state tax rates due primarily to non-deductible lobbying expenses and tax shortfalls related to share-based payments. Our effective tax rate for the three months ended June 30, 2013 was higher than statutory federal and state tax rates due primarily to non-deductible lobbying expenses.

Six Months Ended June 30, 2012 and 2013—In the six months ended June 30, 2012 and 2013, we recorded a provision for income taxes representing effective tax rates of 45.2% and 40.8%, respectively. Our effective tax rate for the six months ended June 30, 2012 was higher than statutory federal and state tax rates due primarily to non-deductible lobbying expenses and tax shortfalls related to share-based payments. Our effective tax rate for the six months ended June 30, 2013 was higher than statutory federal and state tax rates due primarily to non-deductible lobbying expenses.

Liquidity and Capital Resources

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At June 30, 2013, our cash and cash equivalents totaled $89.7 million. Cash equivalents, which are comprised of financial instruments with an original maturity of 90 days or less from the date of purchase, primarily consist of money market funds. At December 31, 2012, our cash and cash equivalents totaled $140.8 million. The decrease in cash and cash equivalents reflects $59.0 million used to repurchase 2.9 million shares of common stock, partially offset by cash flows generated from operations.

On September 10, 2012, we announced that our board of directors approved a stock repurchase program authorizing us to purchase up to $30 million of our common stock and on March 6, 2013, we announced that our board of directors increased the approved repurchase amount under this program to $60 million. Purchases under this program were made in the open market and complied with Rule 10b-18 under the Securities Exchange Act of 1934, as amended. The cost of the repurchased shares was funded from available working capital.

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

Stock repurchase activity under our stock repurchase programs during the six months ended June 30, 2013 is summarized as follows (in thousands, except share and per share amounts):

	Total Number of Shares Repurchased	Average Price Paid per Share (2)	Amount of Repurchase
Cumulative balance at December 31, 2012 (1)	6,397,803	$ 14.22	$ 90,991
Repurchases of common stock	2,911,466	$ 20.27	59,007
Cumulative balance at June 30, 2013 (1)	9,309,269	$ 16.11	$ 149,998

(1) Cumulative balances at December 31, 2012 and June 30, 2013 consist of shares repurchased in connection with our stock repurchase programs announced on September 10, 2012, as well as previous stock repurchase plans announced in 2011, 2010 and 2008.
(2) Average price paid per share includes commissions.

In addition to the shares repurchased under our repurchase programs as of June 30, 2013, we have in treasury 206,435 shares that were previously surrendered by employees to satisfy tax withholdings due in connection with the vesting of certain restricted stock units. As of December 31, 2012 and June 30, 2013, we had a total of 6,556,303 million shares and 9,515,704 million shares, respectively, held in treasury.

The following table presents a summary of our cash flows for the six months ended June 30, 2012 and 2013 (in thousands):

	Six Months Ended June 30,	
	2012	2013
Net cash provided by operating activities	$ 12,725	$ 6,097
Net cash used in investing activities	$ (8,389)	