Health Insurance Innovations, Inc.
Form 10-K
March 02, 2017

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM 10-K

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

For the fiscal year ended December 31, 2016

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

For the transition period from _____ to _____

COMMISSION FILE NUMBER 001-35811

Health Insurance Innovations, Inc.

(Exact name of registrant as specified in its charter)

Delaware	**46-1282634**
(State or other jurisdiction of incorporation or organization)	**(IRS Employer Identification No.)**

15438 North Florida Avenue, Suite 201

Tampa, Florida 33613

(Address of principal executive offices) (zip code)

Registrant's telephone number, including area code:

(877) 376-5831

SECURITIES REGISTERED PURSUANT TO SECTION 12(b) OF THE ACT:

Title of each class	**Name of each exchange on which registered**
Class A common stock, par value $0.001 per share	**NASDAQ Global Market**

SECURITIES REGISTERED PURSUANT TO SECTION 12(g) OF THE ACT: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes [ ] No [X]

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act. Yes [ ] No [X]

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 Regulation 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 if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. [ ]

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

Large accelerated filer [ ]	Accelerated filer [ ]
Non-accelerated filer [ ] (Do not check if a smaller reporting company)	Smaller reporting company [X]

Indicate by check mark whether the registrant is a shell company (as defined in Exchange Act Rule 12b-2). Yes [ ] No [X]

The aggregate market value of the registrant's Class A and Class B common stock held by non-affiliates of the registrant, as of June 30, 2016, was approximately $27.6 million. Such aggregate market value was computed by reference to the closing price of the Class A common stock as reported on the NASDAQ Global Market on June 30, 2016.

As of March 1, 2017, there were 8,914,717 shares of the registrant's Class A common stock, $0.001 par value per share, outstanding and 6,841,667 shares of the registrant's Class B common stock, $0.001 par value per share, outstanding.

Documents incorporated by reference: Portions of the definitive proxy statement for the 2017 Annual Meeting of Stockholders of the Registrant to be filed subsequently with the SEC are incorporated by reference into Part III of this Annual Report on Form 10-K to the extent indicated herein.

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INTRODUCTION

Health Insurance Innovations, Inc. is a Delaware corporation incorporated on October 26, 2012. In this annual report, unless the context suggests otherwise, references to the "Company," "we," "us" and "our" refer (1) prior to the February 13, 2013 closing of an initial public offering ("IPO") of the Class A common stock of Health Insurance Innovations, Inc. and related transactions, to Health Plan Intermediaries, LLC ("HPI") and its consolidated subsidiaries and (2) after the IPO and related transactions, to Health Insurance Innovations, Inc. and its consolidated subsidiaries. The terms "HII", "HPIH", and "ICE" refer to the stand-alone entities Health Insurance Innovations, Inc., Health Plan Intermediaries Holdings, LLC, and Insurance Center for Excellence, LLC, respectively. The term "Secured" refers to (a) prior to or at the time of their July 17, 2013 acquisition by us, Sunrise Health Plans, Inc., Sunrise Group Marketing, Inc. and Secured Software Solutions, Inc., collectively, and (b) following our July 17, 2013 acquisition, the entities described in (a) and the limited liability companies into which such entities were converted shortly following such acquisition. The term "SIL" refers to Simple Insurance Leads LLC, previously, a partially owned venture we and a third-party formed in June 2013; we sold our interest in SIL to our joint venture partner on March 23, 2015. The terms "HealthPocket" or "HP" refer to HealthPocket, Inc., our wholly owned subsidiary which was acquired by HPIH on July 14, 2014. The term "ASIA" refers to American Service Insurance Agency LLC, a wholly owned subsidiary which was acquired by HPIH on August 8, 2014. HPIH, ICE, Secured, HP and ASIA are consolidated subsidiaries of HII. SIL was a consolidated subsidiary of HII through March 2015.

SPECIAL NOTE REGARDING FORWARD-LOOKING STATEMENTS

We have made statements in "Item 1. Business", "Item 1A. Risk Factors," "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations," and in other sections of this report that are forward-looking statements. All statements other than statements of historical fact included in this report are forward-looking statements. You can identify forward-looking statements by the fact that they do not relate strictly to historical or current facts. These statements may include words such as "may," "might," "will," "should," "expects," "plans," "anticipates," "believes," "estimates," "predicts," "potential" or "continue," the negative of these terms and other comparable terminology. These forward-looking statements, which are subject to risks, uncertainties and assumptions about us, may include projections of our future financial performance, our anticipated growth strategies, anticipated trends in our business and other future events or circumstances. These statements are only predictions based on our current expectations and projections about future events. There are important factors that could cause our actual results, level of activity, performance or achievements and other future events or circumstances to differ materially from the results, level of activity, performance or achievements, events or circumstances expressed or implied by the forward-looking statements, including those factors discussed "Item 1A. Risk Factors".

We cannot guarantee future results, level of activity, performance, achievements, events or circumstances. We disclaim any intention or duty, other than imposed by law, to update any of these forward-looking statements after the date of this report to conform our prior statements to actual results or revised expectations.

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PART I

ITEM 1. BUSINESS

Overview

We are a developer, distributor and cloud-based administrator of affordable individual health and family insurance plans ("IFP") which include short-term medical ("STM") insurance plans, and guaranteed-issue and underwritten hospital indemnity plans. We also develop, distribute and administer supplemental products which includes a variety of additional insurance and non-insurance products such as pharmacy benefit cards, dental plans, vision plans, cancer/critical illness plans, deductible and gap protection plans, and life insurance policies that are frequently purchased as supplements to IFP.

STM plans feature a streamlined underwriting process offering immediate coverage options. STM plans generally offer qualifying individuals insurance benefits for fixed short-term durations. Generally, our IFP premiums are substantially more affordable than the premiums of individual major medical ("IMM") plans which offer lifetime renewable coverage. Through 2016, STM plans provided up to six months, eleven months or 364 days of health insurance coverage with a wide range of deductible and copay levels. On October 31, 2016, the Internal Revenue Service, the Employee Benefits Security Administration, and the U.S Department of Health and Human Services, collectively "HHS," published Internal Revenue Bulletin 2016-47 that, effective January 1, 2017, all STM plans submitted before April 1, 2017 must terminate no later than December 31, 2017, and effective beginning April 1, 2017, set new limits on STM duration to periods of less than three months but allows for re-applications with the same or different health insurance carrier. The impact of the HHS rule could reduce revenues related to STM in the future.

Hospital indemnity plans are insurance products which include both guaranteed-issue and underwritten plans that pay fixed cash benefits for covered procedures and services for individuals under the age of 65. These highly customizable products are on an open provider network without copayments or deductibles and do not have defined policy term lengths.

We design and structure these IFPs and supplemental products on behalf of insurance carriers and discount benefit providers. We market products to individuals through our internal distribution network and we use an external distribution network consisting of non-owned third party licensed agent call centers to market to individuals. For both our internal distribution network and our external distribution network, we administer the IFPs and supplemental products. We manage customer relations via our online member portal, which is available 24 hours a day, seven days a week. Our online enrollment process allows us to aggregate and analyze consumer data and purchasing habits to track market trends and drive product innovation.

Our scalable, proprietary, and web-based technology platform provides customers, whom we refer to as members, immediate access to the products we sell through our internal and third-party distribution channels. The health insurance products we develop are underwritten by insurance carriers, and we assume no underwriting, insurance or reimbursement risk. Members can tailor product selections to meet their personal insurance and budget needs, buy policies and print policy documents and identification cards in real-time. Our technology platform uses abbreviated online applications, some with health questionnaires, to provide an immediate accept or reject decision for products we offer. Once an application is accepted, individuals can use our automated payment system to complete the enrollment process and obtain instant electronic access to their policy fulfillment documents, including the insurance policy, benefits schedule and identification cards. We receive credit card and Automated Clearing House ("ACH") payments directly from members at the time of sale. Our technology platform provides scalability as we add members and on a per-policy-basis, reduces the costs associated with marketing, selling, underwriting and administering policies.

Our sales of IFP and supplemental products focus on the large and under-penetrated segment of the U.S. population who are uninsured or underinsured. These respective classes include individuals not covered by employer-sponsored insurance plans, such as the self-employed, small business owners and their employees, individuals who are unable to afford the rising cost of IMM premiums, underserved "gap populations" that require insurance due to changes caused by life events: new graduates, divorcees, early retirees, military discharges, the unemployed, part-time and seasonal employees and customers seeking health insurance between the open enrollment periods created under the Patient Protection and Affordable Care Act ("PPACA").

As the managing general underwriter of our IFP and supplemental products, we receive all amounts due in connection with the plans we sell on behalf of the providers of the services, third-party commissions and referral fees. We refer to these total collections as premium equivalents, which typically represent a combination of premiums, fees for discount benefit plans (a non-insurance benefit product that supplements or enhances an insurance product), our enrollment fees and referral fees. From premium equivalents, we remit risk premium to carriers and amounts earned by discount benefit plan providers, who we refer to as third-party obligors, such carriers and third-party obligors being the ultimate parties responsible for providing the insurance coverage or discount benefits to the member. Our revenues from above consist of the balance of the premium equivalents.

We collect premium equivalents upon the initial sale of the plan and then monthly upon each subsequent periodic payment under such plan. We receive most premium equivalents through online credit card or ACH processing. As a result, we have limited accounts receivable. We remit the risk premium to the applicable carriers and the amounts earned by third-party obligors on a monthly basis based on the respective compensation arrangements.

We also provide consumers with access to health insurance information search and comparison technology through our website, HealthPocket.com. This free website allows consumers to easily and clearly compare and rank health insurance plans available for an individual, family, or small business, empowering consumers to make health plan decisions and reduce their out of pocket costs. In addition, the data aggregated by HealthPocket ("HP") is used to research consumer needs and to measure product demand to help us design and manufacture high-demand insurance products. HP's revenue is principally derived from referral fees and marketing fees, licensing fees, limited exclusivity fees, and landing page development fees.

In 2015, we launched a direct-to-consumer insurance website that allows consumers to research health insurance trends, comparison shop, and purchase IFP under the AgileHealthInsurance® brand. AgileHealthInsurance.com ("Agile") is one of the few internet sites dedicated to helping consumers understand the benefits of Term Health Insurance. We use the term "Term Health Insurance" to refer to health insurance products of less than one year in duration, such as STM. These IFP plans are the culmination of extensive research on health insurance needs in the PPACA era, and we believe consumers will easily be able to find affordable prices for these plans on AgileHealthInsurance.com. AgileHealthInsurance.com utilizes what we believe is a best-of-class plan comparison and online enrollment tool, to accompany these new plans. The underlying technology was developed by engineers with decades of experience working on top-tier e-Commerce websites known for their ease-of-use.

Health Insurance Industry and Market Opportunity

In recent years there have been major proposed changes to health insurance laws. Some of these proposals were implemented under PPACA and the Health Care and Education Reconciliation Act of 2010 ("HCERA"), which we collectively refer to as "Healthcare Reform". These reforms imposed requirements on a broad segment of the population, including a mandate that most individuals carry health insurance or face tax penalties; tax credits and subsidies for the policy premium costs of IMM plans for qualifying individuals; the establishment of a mandatory set of ten Essential Health Benefits for IMM plans; a mandate that certain employers offer most of their employees group health insurance coverage or face tax penalties; prohibitions against insurance companies that offer IMM insurance plans using pre-existing health conditions as a reason to deny an application for health insurance; and medical loss ratio ("MLR") requirements that require each health insurance carrier to spend a certain percentage of its IMM premium revenue on reimbursement for clinical services and activities that improve healthcare quality. Among other things, these changes resulted in a dramatic increase in the unsubsidized average premium for IMM plans as compared to the pre-reform IMM market. As a provider of IFP products, we benefit from the exemption of short-term medical plans (i.e., those with durations less than one year) from the MLR requirements and pre-existing condition prohibitions but are disadvantaged by the tax penalties, to which those insured under IFP plans remain subject.

The implementation of Healthcare Reform has, among other things, increased the unsubsidized average premium for IMM plans, caused carriers to narrow networks under IMM plans and restricted the availability (except in very limited circumstances) to open enrollment periods. Our IFP plans' affordable premium prices, wide acceptance among healthcare providers and year-round availability provide consumer value not available under PPACA health plans. In addition, Healthcare Reform mandates MLR thresholds that require that IMM carriers use 80% to 85% of all premiums collected to pay claims. This has significantly reduced agent commission rates on IMM policies, forcing many agents to abandon the traditional face-to-face IMM sales model. Since 2014, IMM carriers are also subject to a pre-existing condition mandate requiring them to accept all customers regardless of their pre-existing conditions and to cover all ten Essential Health Benefits. These required coverages further increases the cost of IMM coverage. Unlike IMM plans, our IFP products are not subject to narrow networks and are exempt from the minimum MLR thresholds, "must-carry" pre-existing conditions requirements, and Essential Health Benefits requirements under Healthcare Reform, allowing us to offer more attractive commission rates to our distributors while providing products with average premium cost significantly more affordable than unsubsidized PPACA health plans. We believe these dynamics in the health insurance industry present an opportunity to increase our market share in the individual health insurance market.

In addition, Healthcare Reform also required the establishment of health insurance exchanges ("Exchanges") where individuals can select and purchase health insurance plans. We believe that our STM products will be an attractive option to non-subsidized on- and off- Exchange health insurance policies. Moreover, studies have shown that consumers are increasingly accessing the internet to find affordable health insurance solutions. The current number of internet users in the United States continues to grow and, according to a report published by Pew Research Center, represented 85% of the population in 2013. In addition, according to the same survey, 72% of internet users looked online for information related to health insurance.

On June 10, 2016, HHS proposed rule 2016-13583, that impacts STM insurance. On October 31, 2016, HHS published the rule, Internal Revenue Bulletin 2016-47, substantially as proposed despite opposition from significant stakeholders during the open comment period. The rule limits STM duration to periods of less than three months but allows for re-applications with the same or different health insurance carrier. The rule also requires notification of non-compliance with the minimum essential coverage standards set forth in the Affordable Care Act. The rule goes into effect on January 1, 2017 however neither HHS nor the states will enforce the rule regarding duration or renewal of STM plans until April 1, 2017.

During the recent Presidential election campaigns, changes to PPACA were proposed. Since the election, there have been several proposals for changes to Health Insurance laws and regulations. The only actual change announced to date is the "Executive Order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal" which includes a requirement for Insurance Commissioners and others to "encourage the development of a free and open market in interstate commerce for the offering of healthcare services and health insurance, with the goal of achieving and preserving maximum options for patients and consumers." One practical effect has been that the IRS no longer requires filers to indicate whether they have PPACA compliant health insurance.

We believe that one of the consequences of the recent proposals is that some buyers of health insurance will move from IMM to STM or other products we offer.

These ongoing changes in the health insurance industry have expanded and reshaped our target market and we believe the market will continue to evolve. We intend to aggressively pursue opportunities to help meet consumers' needs for affordable health insurance. We believe that our technology platform, product focus and industry expertise will allow us to gain an increasing share of this growing market.

Our Strategy

Our objective is to continue to expand our business and increase our presence in the affordable, web-based health insurance solutions market. Our principal strategies to meet this objective are:

Drive Continuous Product Innovation. We constantly strive to diversify our product portfolio to provide consumers with more choices for their health insurance needs. In addition to our long-standing relationships with our insurance carriers, we continue to develop relationships with new carriers to improve and increase our product mix to help our customers find the right insurance coverage at the right price points while providing new revenue streams to the Company. The expected changes to PPACA are likely to lead to additional opportunities for customers to obtain health insurance coverage appropriate to their needs.

Enhance the Consumer Experience. We have invested significant resources and strive to be market leaders in our customer service and compliance areas, utilizing new technology and additional personnel.

Online sales experience via AgileHealthInsurance.com. In 2015, we launched a direct-to-consumer insurance website that allows consumers to research health insurance trends, comparison shop, and purchase IFP under the AgileHealthInsurance® brand. AgileHealthInsurance.com is one of the few internet sites dedicated to helping consumers understand the benefits of Term Health Insurance. We will continue to expand our direct to consumer web presence with continued focus on its profitability.

Strengthen and Grow Traditional Distribution Channels. The extensive traditional distribution network we access includes owned and independent call centers that utilize licensed agents to sell insurance products. We offer an appealing, incentive-based compensation structure to our distributors that we believe motivates distributors to work with us. By continuing to offer highly competitive commission rates and advance commission arrangements, we believe we will continue to attract new distributors as the insurance marketplace continues to evolve, and we intend to continue to grow our relationships with traditional distributors.

Strategic acquisitions and other transactions. We may acquire, or invest in, companies, products or technologies that complement our current products, enhance our market coverage, technical capabilities or production capacity, or offer growth opportunities.

Our Competitive Strengths

Proprietary, Web-Based, Direct-to-Consumer Technology Platforms

Since we began operations in 2008, we have invested significant financial and human resources in building a unique and scalable proprietary, web-based technology platform. Our technology represents a distinct competitive advantage as it reduces the need for customer care agents, the time associated with quoting, billing, underwriting, fulfillment, sale and marketing and provides significant operating leverage as we add members and product offerings. We have acquired the intellectual property rights to certain software-based technologies as further explained below.

Automated Real-Time Integrated E System ("A.R.I.E.S.")

A.R.I.E.S. is our proprietary product, distribution, and customer management platform. We believe A.R.I.E.S represents a distinct competitive advantage as it reduces the need for customer care agents and provides significant operating leverage as we add members and product offerings. The A.R.I.E.S. platform processes and combines data that is used in insurance plan and product design, sales and distribution of our products and product bundles, member services, business and regulatory compliance, and general reporting. Key elements of A.R.I.E.S. include:

Quote-Buy-Print. Individuals access our technology platform through our distributors and can quote products and buy and print their policy documents and identification cards anytime, anyplace.

Automated Underwriting. The entire underwriting process is handled by A.R.I.E.S. through the use of health questionnaires approved by the insurance carriers. Because our IFP products are largely targeted to healthy individuals who do not have pre-existing conditions and our hospital indemnity plans are guaranteed-issue, we do not have a traditional underwriting department. Underwriting for IFP products is an immediate accept or reject decision based on a prospective member's answers to an abbreviated online health-related questionnaire.

Multiple Value-Added Products. Consumers are able to supplement our IFP offerings with supplemental products such as pharmacy benefit cards, dental plans, vision plans and cancer/critical illness plans. Our technology platform makes it possible for us to instantly offer these bundled products to fit member needs.

Turn-Key Solution. Our technology platform is a turnkey solution, allowing distributors to tailor their offering to meet member needs and can be customized to enhance the experience of an affinity group or employer.

Payment. Through our online platform, we receive credit card and ACH payments directly from members at the time of sale and automatically process recurring payments.

Member Services. Members have the ability to log-in and change payment information and print new identification cards, all without the need of a customer service representative.

Verification and Compliance. We have incorporated eSign technology from Adobe, Inc. on our platform to streamline compliance by providing real-time verification to our members' mobile devices. This technology has allowed us to further automate our compliance program, enhancing quality while minimizing overhead.

Seamless Integration with AgileHealthInsurance®. Our A.R.I.E.S. platform integrates directly with our recently developed direct to consumer AgileHealthInsurance.com platform.

Established Long-Standing Insurance Carrier Relationships

One of our core strengths is long-standing relationships with some of the leading insurance carriers in the United States, which enables us to offer our IFP and supplemental products on our technology platform. We have entered into

written contracts with each of these carriers pursuant to which we sell the carriers' health plans and supplemental products in exchange for the payment of commissions that vary by carrier and by plan. These contracts are typically non-exclusive and terminable by either party on notice or at the expiration of the term. In some cases, an amendment or termination of an agreement may impact the commissions we are paid on health insurance plans and products that we have already sold through the carrier.

For the year ended December 31, 2016, three carriers accounted for 60% of our premium equivalents and for the year ended December 31, 2015, two carriers accounted for 70% of our premium equivalents. For the year, HCC Life Insurance Company ("HCC") accounted for 22% of our premium equivalents, Unified Life Insurance Company accounted for 20%, and Companion Life Insurance Company accounted for 18%. The Company anticipates that its premium equivalents in 2017 will continue to be concentrated among a small number of carriers. As a part of the Company's strategy of improving and increasing its product mix by seeking to add innovative new products, the Company anticipates that its carrier concentration may decrease in the future, but there is no assurance that it will do so.

Our management team has developed close relationships with the senior management teams of many of our insurance carriers. We believe that the nature of our relationships with our insurance carriers, combined with our product knowledge and technology platform, allow us to provide value-added products to our members. Our relationships with highly rated insurance carriers include AXIS Insurance Company, Everest Reinsurance Company, Companion Life Insurance Company, Standard Life and Accident Insurance Company, and Nationwide Mutual Insurance among others. We also continue to develop relationships with new carriers to help us expand our product portfolio.

Long-Term Relationships with Licensed Insurance Distributors

We believe our product expertise, our relationships with multiple insurance carriers, our focus on compliance and our technology platforms make us an partner of choice for our distributors. We have extensive knowledge of the individual health insurance products that we design and fulfill, which allows us to assist our distributors in placing business. Our management team has built a broad distribution network and continuously adds new independent distributors.

Seasoned Management Team

Our management team has substantial experience and long-standing relationships developed over long periods in the insurance and online insurance marketing industries. Our management team draws on its industry experience to identify opportunities to expand our business and collaborate with insurance carriers and distributors to help develop products and respond to market trends.

Our Products

Our differentiated product offerings allow us to build leading positions in our target markets for insurance and related products. The key products we provide include:

Short-Term Medical Plans. Through 2016, STM plans provided up to six months, eleven months, or 364 days of health insurance coverage with a wide range of deductible and copay levels. On October 31, 2016, the Internal Revenue Service, the Employee Benefits Security Administration, and the U.S Department of Health and Human Services, collectively "HHS," published Internal Revenue Bulletin 2016-47 that, effective January 1, 2017, all STM plans submitted before April 1, 2017 must terminate no later than December 31, 2017, and effective beginning April 1, 2017, set new limits on STM duration to periods of less than three months but allows for re-applications with the same or different health insurance carrier. Because the STM plans we offer do not cover pre-existing and often chronic health conditions, and since STM policies terminate after their initial term, these policies have been designed by us with generally substantially lower customer premiums as compared to unsubsidized Exchange or off-Exchange IMM insurance. STM plans generally offer some similar benefits for qualifying individuals as many IMM plans. For example, both STM plans and most silver IMM plans offer a choice of deductibles, a choice of coinsurance, coverage for emergency room care, surgeries, x-rays, lab work, diagnostics, doctor office co-payments, and preferred provider organization network discounts. However, while IMM plans cover prescription drugs, pre-existing conditions and preventive care, STM plans provide optional coverage for prescription drugs and do not cover pre-existing conditions or preventive care unless mandated by the state law. STM plans also do not cover certain medical events such as pregnancy.

***Hospital Indemnity Plans*.** Our hospital indemnity plans provide individuals with a daily cash benefit for hospital treatment and doctor office visits as well as accidental injury and death or dismemberment benefits. The claims process for hospital indemnity plans is streamlined: the member simply provides proof of hospitalization and the carrier pays the predetermined benefits. These policies are primarily used by customers who do not have adequate health insurance and do not qualify for other plans or who wish to supplement existing coverage, typically in conjunction with high deductible plans.

***Supplemental Products*.** We provide numerous low-cost supplemental insurance and discount benefit products, including pharmacy benefit cards, dental plans, vision plans and cancer/critical illness plans, deductible and gap protection plans, and life insurance policies that are frequently purchased as supplements to IFP. These are typically monthly programs with automatic renewal which are not affected by the changes to rules relating to the maximum duration or renewal of STM products.

Sales and Marketing

Our sales and marketing initiatives primarily consist of hiring experienced sales professionals to strengthen our relationships with existing and potential third-party distributors, implementing marketing campaigns and attending industry-sponsored events. We utilize our owned call center and independent third-party distributors and independent brokers to market our products directly to potential members. Our sales and marketing activities also include internal referral generation and acquisition, customer referrals and online marketing. We focus on building brand awareness among our distributors and members, increasing the number of distributors and converting sales leads into buyers.

We derive a significant portion of our AgileHealthInsurance® website traffic through contractual marketing relationships with online and offline businesses that promote AgileHealthInsurance® to its customers and users. These marketing relationships include online advertisers, content providers and insurance lead aggregators. We also attract website traffic from consumers who search for health insurance through internet search engines, such as Google, Bing and Yahoo!. A critical factor in attracting consumers to our website is whether we are prominently displayed in response to internet searches broadly relating to health insurance topics. As part of this marketing strategy, we employ both algorithmic listings and paid advertisements to attract consumers to our website.

Seasonality

Our business of marketing IFP and supplemental plans is subject to seasonal fluctuations that we believe have been largely impacted by Healthcare Reform. Beginning in 2013, under Healthcare Reform, open enrollment periods were created. During these periods, the most recent of which began in the fourth quarter of 2016 and continued into the first quarter of 2017, individuals can enroll in individual insurance programs. During the times that these open enrollment periods are closed, we have the capability to sell our IFP products as an alternative health insurance option for consumers who are ineligible for plans under PPACA. During the four open enrollment periods to date, we experienced significant fluctuations in sales. We believe that as the market matures, sales will become more predictable and less subject to swings. Other seasonality trends may develop and the existing seasonality and consumer behavior that we have experienced to date may change as the implementation of Healthcare Reform

continues and our markets continue to change. For instance, we believe that HealthPocket will be a largely seasonal business as a higher level of traffic to HealthPocket.com will come during the Medicare and PPACA open-enrollment periods.

Competition

The market for selling insurance products is highly competitive and the sale of health insurance over the internet is rapidly evolving. We compete with individuals and entities that offer and sell health insurance products utilizing traditional distribution channels, as well as the internet. Our current and potential competitors include:

Traditional local insurance agents. There are thousands of local insurance agents across the United States who sell health insurance products in their communities. We believe that the vast majority of these local agents offer health insurance without significantly utilizing the internet or technology other than simple desktop applications such as word processing and spreadsheet programs. Some traditional insurance agents, however, utilize general agents that offer online quoting services and other tools to obtain quotes from multiple carriers and prepare electronic benefit proposals to share with their potential customers. These general agents typically offer their services only for the small and mid-sized group markets (not the individual and family markets) and operate in only a limited geographic region. Additionally, some local agents use the internet to acquire new consumer referrals from companies that have expertise in internet marketing. These “lead aggregator” companies utilize keyword search, primarily paid keyword search listings on Google, Bing and Yahoo! and other forms of internet advertising, to drive internet traffic to the lead aggregator’s website. The lead aggregator then collects and sells consumer information to agents and, to a lesser extent, to carriers, both of whom endeavor to close the referrals through traditional offline sales methods.

Health insurance carriers’ “direct-to-member” sales. Some carriers directly market and sell their plans and products to consumers through call centers and their own websites. Although we offer health insurance plans and products for many of these carriers, they also can compete with us by offering their products directly to consumers. Most of these carriers have superior brand recognition, extensive marketing budgets and significant financial resources to influence consumer preferences for searching and buying health insurance online. The carriers we choose to represent, however, do not have a competitive price advantage over us. Because individual and family plan health insurance prices are regulated in all U.S. jurisdictions, a consumer is entitled to pay the same price for a particular plan, whether the consumer purchased the plan directly from one of our carrier companies or from us.

Online agents. There are a number of agents that operate websites and provide a limited online shopping experience for consumers interested in purchasing health insurance (e.g., online quoting of health insurance product prices). Some online agents also sell non-health insurance products such as auto insurance, life insurance and home insurance.

Exchanges. Government-administered Exchanges have been established under Healthcare Reform where individuals can select and purchase health insurance plans. These Exchanges have not been in existence for sufficient duration to forecast reliably their usage by consumers. Press accounts indicate that private companies have established their own websites modeled after the Exchanges required by Healthcare Reform to facilitate the purchase of off-Exchange plans by consumers. However, these Exchanges are typically limited and PPACA compliant IMM plans which are only available for sale during Health Care Reform authorized open enrollment periods.

National insurance brokers. Although insurance brokers have traditionally not focused on the affordable IFP market, they may enter our markets and could compete with us. These large agencies have existing relationships with many of our carrier companies, are licensed nationwide and have large customer bases and significant financial, technical and marketing resources to compete in our markets. Some of these large agencies and financial services companies have worked with us in order to offer our services to their customer and member bases.

We believe the principal factors that determine our competitive advantage in the online distribution of health insurance include the following:

- affordable, value added healthcare products;
- proprietary, web-based technology platform;
- strength of carrier relationships and depth of technology integration with carriers;
- data-driven product design;
- highly automated compliance program;
- strength of distribution relationships; and
- proven capabilities measured in years of delivering sales and creating and using reliable technology.

Intellectual Property

Our success depends, in part, on our ability to protect our intellectual property and proprietary technology, and to operate our business without infringing or violating the intellectual property or proprietary rights of others. We rely on a combination of copyrights, trademarks, domain names, trade secrets, intellectual property licenses and other contractual rights (including confidentiality and non-disclosure agreements), including our proprietary technology. However, these intellectual property rights may not prevent others from creating a competitive online platform or otherwise competing with us.

For more information see Item 1A. Risk Factors—"We rely on third-party vendors to develop, host, maintain, service and enhance our technology platform" and Item 1A. Risk Factors—"Our failure to obtain, maintain and enforce the intellectual property rights on which our business depends could have a material adverse effect on our business, financial condition and results of operations."

Healthcare Laws and Regulations

Our business is subject to extensive, complex and rapidly changing federal and state laws and regulations. Various federal and state agencies have discretion to issue regulations and interpret and enforce healthcare laws. While we believe we comply in all material respects with applicable healthcare laws and regulations, these regulations can vary significantly from jurisdiction to jurisdiction, and interpretation of existing laws and regulations may change. Federal and state legislatures also may enact various legislative proposals that could materially impact certain aspects of our business. The following are summaries of key federal and state laws and regulations that impact our operations:

Healthcare Reform

In March 2010, Healthcare Reform was signed into law. Healthcare Reform contains provisions that have changed and will continue to change the health insurance industry in substantial ways. For example, Healthcare Reform includes a mandate requiring individuals to be insured or face tax penalties; a mandate that employers with over 50 employees offer their employees group health insurance coverage or face tax penalties; prohibitions against insurance companies that offer IMM plans using pre-existing health conditions as a reason to deny an application for health insurance; MLR 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 healthcare quality; establishment of Exchanges to facilitate access to, and the purchase of, health insurance; and subsidies and cost-sharing credits to make health insurance more affordable for those below certain income levels.

Healthcare Reform amended various provisions in many federal laws, including the Internal Revenue Code, the Employee Retirement Income Security Act of 1974 and the Public Health Services Act. Healthcare Reform is being implemented by the Department of Health and Human Services, the Department of Labor and the Department of Treasury. Many of the PPACA regulations became effective on or before January 1, 2014. Through these regulations, the federal government and its implementing agencies may regulate or otherwise impose restrictions upon all types of health insurance including the IFP products that we sell. Although the Supreme Court of the United States upheld Healthcare Reform's mandate requiring individuals to purchase health insurance in 2012, some uncertainty about whether parts of Healthcare Reform or PPACA regulations will remain in effect or be further amended is expected to continue with the possibility of future litigation with respect to certain provisions as well as legislative efforts to repeal and defund portions of Healthcare Reform or Healthcare Reform in its entirety. We cannot predict the outcome of any future legislation or litigation related to Healthcare Reform. As described under "Item 1. Business—Health Insurance Industry and Market Opportunity," Healthcare Reform has resulted in profound changes to the individual health insurance market and our business, and we expect these changes to continue.

Internal Revenue Bulletin: 2016-47

On June 10, 2016, the Internal Revenue Service, the Employee Benefits Security Administration, and the U.S Department of Health and Human Services, collectively "HHS," proposed rule 2016-13583, that impacts STM insurance. On October 31, 2016, HHS published the rule substantially as proposed despite opposition from significant stakeholders during the open comment period. The rule limits STM duration to periods of less than three months but allows for re-applications with the same or different health insurance carrier. The rule also requires notification of non-compliance with the minimum essential coverage standards set forth in the Affordable Care Act. The rule goes into effect on January 1, 2017 however neither HHS nor the states will enforce the rule regarding duration or renewal of STM plans until April 1, 2017.

Anti-Kickback Laws

In the United States, there are federal and state anti-kickback laws that generally prohibit the payment or receipt of kickbacks, bribes or other remuneration given with the intent to induce the referral of patients or other health-care program related business. The federal Anti-Kickback Statute makes it unlawful for individuals or entities to knowingly and willfully offer, pay, solicit, or receive any remuneration, directly or indirectly, to induce or reward referrals of items or services reimbursable by a federal healthcare program. Where remuneration is paid purposefully to induce or reward referrals of items or services payable by a federal healthcare program, the Anti-Kickback Statue is violated. For purposes of the Anti-Kickback Statute, "remuneration" includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind. There are also state law corollaries to the federal Anti-Kickback Statute. Penalties for violations include criminal penalties and civil sanctions such as fines, imprisonment, and possible exclusion from federal healthcare programs.

Federal Civil False Claims Act and State False Claims Laws

The federal civil False Claims Act imposes liability on any person or entity who, among other things, knowingly presents, or causes to be presented, a false or fraudulent claim for payment by a federal healthcare program. The "qui tam" or "whistleblower" provisions of the False Claims Act allow a private individual to bring actions on behalf of the federal government alleging that the defendant has submitted a false claim to the federal government, and to share in any monetary recovery. There are also state law corollaries to the federal False Claims Act. Our future activities relating to the manner in which we sell and market our services may be subject to scrutiny under these laws.

HIPAA, Privacy Laws and Data Security Regulations

By processing data on behalf of our clients and customers, we are subject to specific compliance obligations under privacy and data security-related laws, including the Health Insurance Portability and Accountability Act ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), and related state laws. We are also subject to federal and state security breach notification laws, as well as state laws regulating the processing of protected personal information, including laws governing the collection, use and disclosure of social security numbers and related identifiers.

The regulations that implement HIPAA and the HITECH Act establish uniform standards governing the conduct of certain electronic healthcare transactions and protecting the security and privacy of individually identifiable health information maintained or transmitted by healthcare providers, health plans, and healthcare clearinghouses, all of which are referred to as "covered entities," and their "business associates" (which is anyone who performs a service on behalf of a covered entity involving the use or disclosure of protected health information and is not a member of the

covered entity's workforce). Our carrier companies' and our clients' health plans generally will be covered entities, and as their business associate they may ask us to contractually comply with certain aspects of these standards by entering into requisite business associate agreements. Under the new HIPAA regulations, business associates and covered entities can each be held individually responsible for privacy and data security breaches.

HIPAA Healthcare Fraud Standards

The HIPAA healthcare fraud statute created a class of federal crimes known as the "federal healthcare offenses," including healthcare fraud and false statements relating to healthcare matters. The HIPAA healthcare fraud statute prohibits, among other things, executing a scheme to defraud any healthcare benefit program while the HIPAA false statements statute prohibits, among other things, concealing a material fact or making a materially false statement in connection with the payment for healthcare benefits, items or services. Entities that are found to have aided or abetted in a violation of the HIPAA federal healthcare offenses are deemed by statute to have committed the offense and are punishable as a principal.

State Privacy Laws

In addition to federal regulations issued under HIPAA, some states have enacted privacy and security statutes or regulations, or State Privacy Laws, that govern the use and disclosure of a person's medical information or records and, in some cases, are more stringent than those issued under HIPAA. These State Privacy Laws include regulation of health insurance providers and agents, regulation of organizations that perform certain administrative functions such as utilization review or third-party administration, issuance of notices of privacy practices, and reporting and providing access to law enforcement authorities. In those cases, it may be necessary to modify our operations and procedures to comply with these more stringent State Privacy Laws. If we fail to comply with applicable State Privacy Laws, we could be subject to additional sanctions.

Consumer Protection Laws

Federal and state consumer protection laws are being increasingly enforced by the United States Federal Trade Commission ("FTC"), the Federal Communications Commission ("FCC"), and the various states' attorneys general to regulate the collection, use, storage and disclosure of personal or patient information, through websites or otherwise, and to regulate the presentation of web site content and to regulate direct marketing, including telemarketing and telephonic communication. Courts may also adopt the standards for fair information practices promulgated by the FTC, concerning consumer notice, choice, security and access.

As part of the payment-related aspects of our business, we may also undertake security-related obligations arising out of the USA Patriot Act, Gramm-Leach-Bliley Act and the Payment Card Industry guidelines applicable to card systems. These requirements generally require safeguards for the protection of personal and other payment related information.

State Insurance Laws

Some of the states in which we operate have laws prohibiting unlicensed persons or business entities, including corporations, from making certain direct and indirect payments or fee-splitting arrangements with licensed insurance agents and brokers. Possible sanctions for violation of these restrictions include loss of license and civil penalties. These statutes vary from state to state, are often vague, and have seldom been interpreted by the courts or regulatory agencies.

State insurance laws also require us to maintain any combination of insurance agency, broker, and third party administrator licenses in each state in which we transact health insurance business and adhere to sales, documentation and administration practices specific to that state. In addition, each of our employees who solicits, negotiates, sells or transacts health insurance business for us must maintain an individual insurance agent or broker license in one or more states. Because we transact business in the majority of states, compliance with health insurance-related laws, rules and regulations is difficult and imposes significant costs on our business.

In certain states, some of our products may only be available as a group association plan. In these states members must enroll in group programs or associations in order to access certain of our insurance products, benefits and services. We have entered into relationships with such associations in order to provide individuals access to our products. For example, we have an agreement with Med-Sense Guaranteed Association ("Med-Sense"), a non-profit association that provides membership benefits to individuals and gives members access to certain of our products. Under the agreement, we primarily market membership in the association and collect certain fees and dues on its behalf. In return, we have sole access to its membership list, Med-Sense exclusively endorses the insurance products

that we offer and we receive compensation for our services. Our agreement with Med-Sense is automatically renewable for one-year terms, unless terminated on 120 days written notice by either party. The agreement is also terminable on 15 days' written notice by either party under certain circumstances, such as in the case of a breach.

Employees

As of December 31, 2016, we had 174 employees, of which 172 were full-time employees. As of December 31, 2015, we had 192 employees, of which 191 were full-time employees. We have not experienced any work stoppages and consider our employee relations to be good. None of our employees are represented by a labor union.

ITEM 1A. RISK FACTORS

In addition to the other information set forth in this report, you should carefully consider the following factors, which could materially affect our business, financial condition or results of operations in future periods. The risks described below are not exhaustive and are not the only risks facing our Company. Additional risks not currently known to us or that we currently deem to be immaterial also may materially adversely affect our business, financial condition or results of operations in future periods.

Risks Relating to Our Business and Industry

Our business practices and the business practices of our third-party distributors and carriers are currently being reviewed by various state insurance regulators and the results of such reviews may adversely affect our business and results of operations.

Our business practices and the business practices of our third-party distributors and carriers are heavily regulated by each state in the United States and various federal agencies. State regulators require that we and our third-party distributors adhere to sales, documentation, and administration practices specific to each state. We are currently subject to several state regulatory examinations and actions as further described below and in "Legal Proceedings" in Part I, Item 3 of this report.

The Indiana Department of Insurance has commenced a multistate examination providing for the review of an insurance company whose products we previously distributed, the examination of which will include a review of our activities and whether our practices are in compliance with Indiana insurance law and the similar laws of other states participating in the examination. The Indiana Department of Insurance is serving as the managing participant of the multistate examination, and the examination includes, among other things, a review of whether the insurance company (and our Company) has engaged in any unfair or deceptive acts or insurance business practices. As of March 1, 2017, forty-two states have joined the multistate examination.

In addition to the multistate examination, the Office of the Montana State Auditor, Commissioner of Securities and Insurance ("CSI") has initiated an administrative action against us. We were among more than two dozen separate parties named by the CSI in a Notice of Proposed Agency Action on May 12, 2016, that alleges potential violations of the Montana Insurance Code. The Notice, directed to us as well as a large pool of third-party respondents ranging from very large companies to individual insurance agents, indicated that the CSI was concerned with the possibility of unfair trade practices, potentially unlicensed insurance practices, or agents that were not properly appointed to the insurance carriers for whom products were being offered. Seventeen of the named parties, including our Company, requested a hearing before the CSI to contest the state's allegations and, in addition to reviewing our own data, we have requested certain materials, data, and information from the CSI in order to do so. Pending the resolution of the matter, the CSI summarily suspended our license to conduct business in Montana. The state formally granted our request to be heard on the issues, and a neutral Hearing Officer, experienced in the insurance industry, has been appointed to hear the matter. We have been cooperative with the CSI, and we have begun the routine exchange of information attendant to the hearing process so we can properly measure and gauge the potential of the allegations. Additional requests for information are ongoing as we work to understand the CSI's concerns. While it is too early to assess whether the CSI's notice and the investigation of these organizations and individuals will have a material impact on us, based on the nature of the allegations and evidence provided by the CSI during the third and fourth quarters of 2016 and settlement discussions with the CSI in early 2017, we believe that a loss arising from the future assessment of a civil penalty against us in the range of $100,000 to $315,000 is probable but may vary based on the early stages of this matter.

We have also received notification of a civil investigative demand from the Massachusetts Attorney General's Office ("MAG"). As part of the MAG's regulatory oversight of the Massachusetts health care system and its corresponding authority to request documents from market participants, the MAG has requested that we provide certain information and documents. The information requested will be used to review our sales and marketing practices, and ensure we are in compliance with Massachusetts laws and regulations. Additionally, our materials and sales and marketing practices will be evaluated in order to ensure that they are neither deceptive nor do they constitute unfair trade practices. We have provided all requested documents and materials and continue to cooperate with the MAG in order to bring the matter to an agreeable conclusion. Based on the nature of the allegations raised by the MAG and based on discussions with them, we believe a loss arising from the future assessment of a civil penalty against the Company is possible however, we have not received any formal settlement offer from the state. We have begun preliminary discussions with the MAG concerning resolution options to avoid the need and cost of a continuing inquiry, and the MAG has indicated it is willing to discuss such options; however, there is no guarantee that we will reach a mutually agreeable resolution. Any formal settlement proposal would need to be approved by the management of the MAG before it is presented to us and as such, the MAG will likely want to engage in additional discovery prior to doing so, and it is too early in the process to estimate a potential range of loss.

In September 2016, the Texas Department of Insurance ("TDI") notified us that it has instituted an enforcement action to investigate alleged violations of advertising rules and third-party administrator license requirements in connection with the sale of our products. In connection with the investigation, the TDI requested certain information, records, and explanations from us, and we delivered a response and the requested information and records in November 2016. Following such date, the TDI has not taken any action, and the TDI has only communicated that it is continuing to review the matter. Our Company's position is that there have been no violations of the advertising or third-party administrator statutes in Texas, although there is no assurance that the TDI will agree with position.

In addition to the above, the states of Florida, Ohio, and South Dakota are reviewing the Company and the sales practices and potential unlicensed sale of insurance by our third-party distributor call centers. While we are aware of these states' reviews, as of March 1, 2017, we have not been presented with any formal administrative action by any of these states, although South Dakota has offered to enter into a consent judgment whereby we would admit to no wrongdoing and pay a civil fine of $55,000. We are not aware of any examination into the sales practices of our owned call center in these states, although we cannot be certain that no such investigation is occurring or will occur.

We are proactively communicating and cooperating with all regulatory agencies involved in the above-described examinations and actions and we have recently developed and enhanced our compliance and control mechanisms. However, it is too early to determine whether any of these regulatory matters will have a material impact on our business. Any adverse finding could result in significant penalties or other liabilities and/or a requirement to modify our marketing or business practices and the practices of our third-party distributors, which could harm our business, results of operations or financial condition. Moreover, an adverse regulatory action in one jurisdiction could result in penalties and adversely affect our license status or reputation in other jurisdictions due to the requirement that adverse regulatory actions in one jurisdiction be reported to other jurisdictions. For additional information regarding our current state regulatory matters, see "Legal Proceedings" in Part I, Item 3 of this report.

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The market for health insurance in the United States is rapidly evolving, which makes it difficult to forecast demand for our products.

The market for health insurance in the United States is rapidly evolving. Accordingly, our future financial performance will depend in part on growth in this market and on our ability to adapt to emerging demands in this market. We believe demand for our products has been driven in large part by recent regulatory changes, broader use of the internet and advances in technology. It is difficult to predict with any precision the future growth rate and size of our target market. The rapidly evolving nature of the market in which we operate, as well as other factors that are beyond our control, reduce our ability to evaluate accurately our long-term outlook and forecast performance or other operating results. A reduction in demand for our products caused by lack of acceptance, technological challenges, competing offerings or other factors would result in a lower revenue growth rate or decreased revenue, either of which could negatively impact our business and results of operations.

If we are unable to retain our members, our business and results of operations could be harmed.

Our revenue is primarily derived from commissions that insurance carriers pay to us for the health insurance plans and products that we market and that remain in effect. When one of these plans or products is cancelled, or if we otherwise do not remain the administrator of record on the policy, we no longer receive the related commission revenue. Members may choose to discontinue their insurance policies for a number of reasons. For example, our members may choose to purchase new plans or products using a different administrator if, for example, they are not satisfied with our customer service or the plans or products that we offer or because PPACA or other healthcare legislation results in more attractive alternatives for them. Further, members may discontinue their policies because they no longer need STM insurance because, for example, they have received coverage through an employer or spouse. Insurance carriers may also terminate health insurance plans or products purchased by our members for a variety of reasons. Our cost in acquiring a new member is substantially greater than the cost involved in maintaining our relationship with an existing member. If we are not able to successfully retain existing members and limit member turnover, our revenue and operating margins could be adversely affected.

A substantial portion of our business is concentrated in a small number of carriers, and such concentration could make our business more vulnerable to adverse changes in our relationships with carriers.

For the year ended December 31, 2016, three carriers accounted for 60% of our premium equivalents and for the year ended December 31, 2015, two carriers accounted for 70% of our premium equivalents. For the year ended December 31, 2016, HCC Life Insurance Company (“HCC”) accounted for 22% of our premium equivalents, Unified Life Insurance Company accounted for 20%, and Companion Life Insurance Company accounted for 18%. The Company anticipates that its premium equivalents in 2017 will continue to be concentrated among a small number of carriers. On February 1, 2017, we came to mutual agreement with HCC to terminate the terms of our carrier contract with HCC. We no longer sell HCC products through any of our distribution channels. Although we do not expect this

contract termination to have a material impact on our Company revenues, such termination will make us more dependent on the other carriers with which we have been developing relationships.

We typically enter into contractual agency relationships with insurance carriers that are non-exclusive and terminable on short notice by either party for any reason. In many cases, insurance carriers also have the ability to amend the terms of our agreements unilaterally on short notice. Insurance carriers may be unwilling to underwrite our health insurance plans or products or may amend our agreements with them for a variety of reasons, including for competitive or regulatory reasons. Insurance carriers may decide to rely on their own internal distribution channels, including traditional in-house agents, insurance carrier websites or other sales channels, or to market their own plans or products, and, in turn, could limit or prohibit us from marketing their plans or products. Insurance carriers may decide not to underwrite insurance plans or products in the individual health insurance market in certain geographies or altogether. Our carrier relationship could also be affected by lawsuits and regulatory actions against our carriers relating to the products sold by us, as such carriers may seek indemnification or reimbursement from us or may seek to otherwise adversely change their relationship with us. Carriers can be, and two of our carriers have been, subject to lawsuits and regulatory actions of which we could, and have been, named parties. The termination or amendment of our relationship with an insurance carrier could reduce the variety of health insurance plans or products we offer. We also could lose a source of, or be paid reduced commissions for, future sales and could lose renewal commissions for past sales. Our business could also be harmed if we fail to develop new insurance carrier relationships or are unable to offer members a wide variety of health insurance plans and products.

The private health insurance industry in the United States has experienced substantial consolidation over the past several years, resulting in a decrease in the number of insurance carriers. As a result of this trend, it may become necessary for us to offer insurance plans and products from a reduced number of insurance carriers or to derive a greater portion of our revenue from a more concentrated number of insurance carriers as our business and the health insurance industry evolve. Each of these insurance carriers may terminate our agreements with them, and, in some cases, as a result of the termination we may lose our right to receive future commissions for policies we have sold. In addition, one or more of our insurance carriers could experience a failure of its business due to a decline in sales volumes, unavailability of reinsurance, and failure of business strategy or otherwise. Should our dependence on a smaller number of insurance carriers increase, whether as a result of the termination of insurance carrier relationships, further insurance carrier consolidation, business failure, bankruptcy or any other reason, we may become more vulnerable to adverse changes in our relationships with our insurance carriers, particularly in states where we offer health insurance plans and products from a relatively small number of insurance carriers or where a small number of insurance carriers dominate the market. The termination, amendment or consolidation of our relationships with our insurance carriers could harm our business, results of operations and financial condition. For example, for the year ended December 31, 2016, two carriers accounted for 22% and 20%, or 42% of our premium equivalents.

Our business could be harmed if we lose our relationships with independent distributors, fail to maintain good relationships with independent distributors, become dependent upon a limited number of third-party distributors or fail to develop new relationships with third-party distributors.

We depend upon licensed third-party distributors, in addition to our internal distribution network, to sell our products. We typically enter into contractual agency relationships with independent distributors that are non-exclusive and terminable on short notice by either party for any reason. In many cases, these distributors also have the ability to amend the terms of our agreements unilaterally on short notice. Third-party distributors may be unwilling to sell our health insurance plans or products or may amend our agreements with them for a variety of reasons, including for competitive or regulatory reasons. For example, these independent distributors may decide to sell plans and products that bring them a higher commission than our plans and products or may decide not to sell IFP plans at all. Because we rely on a diverse distributor network to sell the products we offer, any loss of relationships with independent distributors or failure to maintain good relationships with independent distributors could harm our business, results of operations and financial condition. We have terminated, and could continue to terminate relationships, with distributors for their failure to follow our compliance standards or their otherwise engaging in problematic business practices. In 2016, we terminated two of our largest distributors for failure to comply with our standards. Further, we believe that we must grow our third-party distributor network in order to achieve our growth plans. If we are unable to grow our independent distributor network and develop new relationships with third-party distributors, our revenue could be adversely impacted.

We depend on relationships with third-parties for certain services that are important to our business. An interruption or cessation of such services by any third-party could have a material adverse effect on our business.

We depend on a number of third-party relationships to enhance our business. For instance, state regulations may require that individuals enroll in group programs or associations in order to access certain insurance products, benefits and services. We have entered into relationships with certain associations in order to provide individuals access to our products. For example, we have an agreement with Med-Sense, a non-profit association that provides membership benefits to individuals and gives members access to certain of our products. Under the agreement, we primarily market membership in the association and collect certain fees and dues on its behalf. In return, we have sole access to its membership list, and Med-Sense exclusively endorses the insurance products that we offer. Members of the association are given access to a wide variety of our products that are otherwise unavailable to non-members. We also have affiliations with other associations offering similar benefits as alternatives to Med-Sense. Med-Sense has the right to cancel its agreement with us at any time by providing 120 days' prior written notice. While we believe we could replace Med-Sense with other group programs or associations, there can be no assurance that any of our other association affiliations could replace Med-Sense or if we could find another association to replace Med-Sense on a timely basis or at all. If we were to lose our relationship with Med-Sense and were unable to find another group program or association on a timely basis or at all, this would have a material adverse effect on our business.

Our ability to offer our services and operate our business is therefore dependent on maintaining our relationships with third-party partners, particularly Med-Sense, and entering into new relationships to meet the changing needs of our

business. Any deterioration in our relationships with such partners, or our failure to enter into agreements with partners in the future could harm our business, results of operations and financial condition. If our partners are unable or unwilling to provide the services necessary to support our business, or if our agreements with such partners are terminated, our operations could be significantly disrupted. We may also incur substantial costs, delays and disruptions to our business in transitioning such services to ourselves or other third-party partners. In addition, third-party partners may not be able to provide the services required in order to meet the changing needs of our business.

We rely on third-party vendors to develop, host, maintain, support and enhance our technology platform.

We are party to agreements with BimSym pursuant to which BimSym provides various professional services relating to our A.R.I.E.S. technology platform, including hosting, support, maintenance and development services. Our ability to offer our services and operate our business is therefore dependent on maintaining our relationships with third-party vendors, particularly BimSym, and entering into new relationships to meet the changing needs of our business. Any deterioration in our relationships with such vendors, or our failure to enter into agreements with vendors in the future could harm our business, results of operations and financial condition. If our vendors are unable or unwilling to provide the services necessary to support our business, or if our agreements with such vendors are terminated, our operations could be significantly disrupted. We may also incur substantial costs, delays and disruptions to our business in transitioning such services to ourselves or other third-party vendors. In addition, third-party vendors may not be able to provide the services required in order to meet the changing needs of our business.

Our business could be harmed if we are unable to secure sufficient financing.

Many distributors utilize our services because we offer attractive compensation, including advances on commissions to provide working capital and defray up-front lead acquisition costs. Advancing commissions requires significant cash outlay by us and as business grows we expect to fund these advances through third-party financing. If we are unable to secure such financing on favorable terms as needed or at all, our ability to advance commissions will be constrained and our business, results of operations and financial position could be adversely affected.

Insurance carriers could reduce the commissions paid to us or change their plan pricing practices in ways that reduce the commissions paid to us, which could harm our revenue and results of operations.

Our commission rates are negotiated between us and each insurance carrier. Insurance carriers have altered, and may in the future alter, the contractual relationships we have with them, either by renegotiation or unilateral action. Also, insurance carriers may adjust their commission. If these contractual changes result in reduced commissions, our revenue may decline.

In addition, insurance carriers periodically adjust the premiums they charge to individuals for their insurance policies. These premium changes may cause members to cancel their existing policies and purchase a replacement policy from a different insurance carrier, either through our platform or through another administrator. We may receive a reduced commission or no commission at all when a member purchases a replacement policy. Also, because insurance rates may vary between insurance carriers, plans and enrollment dates, changes in our enrollment mix may impact our commission revenue. Future changes in insurance carrier pricing practices could harm our business, results of operations and financial condition.

We face intense competition and compete with a broad range of market participants within the health insurance industry. If competition increases, our growth and profits may decline.

The market for selling individual health insurance and supplemental products is highly competitive and, except for regulatory considerations, there are limited barriers to entry. Currently, we believe the cost-effective, high-quality IFP solutions that we distribute to the individual health insurance market are, in most cases, differentiated from our competitors. Because the barriers to entry in our markets are not substantial and competitors have the flexibility to select new health insurance carriers, we believe that the addition of new competitors, or the adoption of our business model by existing competitors, could occur relatively quickly.

We compete with entities and individuals that offer and sell products similar to ours utilizing traditional distribution channels, including insurance agents and brokers across the United States who sell health insurance products in their communities. In addition, many insurance carriers directly market and sell their plans and products to individuals through call centers and their own websites. The Exchanges created under Healthcare Reform represent another means of distribution for IMM policies and are currently receiving substantial publicity and advertising.

Although we offer health insurance plans and products for many insurance carriers, they also compete with us by offering their plans and products directly to individuals or may elect to compete with us by offering their plans and products directly to individuals in the future. We may not be able to compete successfully against our current or future competitors. Some of our current and potential competitors have longer operating histories in the health insurance industry, access to larger customer bases, greater name recognition and significantly greater financial, technical, marketing and other resources than we do. As compared to us, our current and future competitors may be able to:

- undertake more extensive marketing campaigns for their brands and services;
- devote more resources to website and systems development;
- negotiate more favorable commission rates; and
- attract potential employees, marketing partners and third-party service providers.

Further, there are many alternatives to the individual health insurance products that we currently provide. We can make no assurances that we will be able to compete effectively with the various individual health insurance products that are currently available or may become available in the future. Competitive and regulatory pressures may result in our experiencing increased marketing and other costs and loss of market share, or may otherwise harm our business, results of operations and financial condition.

Changes and developments in the health insurance system in the United States, in particular the implementation of Healthcare Reform, could harm our business.

Our business depends upon the private sector of the U.S. insurance system, its role in financing healthcare delivery, and insurance carriers' use of, and payment of commissions to, agents, brokers and other organizations to market and sell health insurance plans and products.

Healthcare Reform contains provisions that have changed and will continue to change the industry in which we operate in substantial ways. In addition, state governments have adopted, and will continue to adopt, changes to their existing laws and regulations in light of Healthcare Reform and related regulations. Future changes may not be beneficial to us.

Certain key members of Congress continue to express a desire to withhold the funding necessary for Healthcare Reform or the desire to repeal or amend all or a portion of Healthcare Reform. Any partial or complete repeal or amendment or implementation difficulties, or uncertainty regarding such events, could increase our costs of compliance and adversely affect our results of operations and financial condition. Conversely, the enforcement of Healthcare Reform and regulations promulgated thereunder could have negative effects on us, including:

- increasing our competition;
- reducing or eliminating the need for health insurance agents and brokers and/or demand for the health insurance that we sell;
- decreasing the number of types of health insurance plans and products available for us to sell, as well as the number of insurance carriers offering such plans and products;
- causing insurance carriers to change the benefits and/or premiums for the plans and products they sell;
- causing insurance carriers to reduce the amount they pay for our services or change their relationships with us in other ways;
- causing IFP policyholders to pay the government a penalty or tax;
- making the cost of IMM more affordable through tax credits and subsidies;
- regulating out stand-alone hospital indemnity plans;
- causing STM policies to be subject to MLR threshold requirements; or
- causing STM policies to be subject to "must carry" pre-existing condition requirements.

Any of these effects could materially harm our business, results of operations and financial condition. For example, the manner in which the federal government and the states implement and enforce Healthcare Reform could substantially increase our competition and member turnover and substantially reduce the number of individuals who purchase insurance through us. Various aspects of Healthcare Reform could cause insurance carriers to limit the type of health insurance plans and products we are able to sell and the geographies in which we are able to sell them. Changes in the law could also cause insurance carriers to exit the business of selling insurance plans and products in a particular jurisdiction, to eliminate certain categories of products or to attempt to move members into new plans and products for which we receive lower commissions. If insurance carriers decide to limit our ability to sell their plans and products or determine not to sell individual health insurance plans and products altogether, our business, results of operations and financial condition could be materially harmed.

Persons who do not enroll in health care insurance plans with minimum essential coverage will be required to pay a penalty to the Internal Revenue Service which commenced in 2016, unless a hardship exception applies. The health insurance products that we sell are not deemed qualified insurance policies and will not exempt our customers from these penalties. If the cost of the insurance policies that we sell, together with any penalties that our potential customers could be required to pay, are not less than the cost of qualifying health insurance policies, or our policies are otherwise perceived as inferior to qualifying insurance policies by potential customers, our business, revenues and results of operations could be materially harmed.

Final HHS rule may have a material adverse impact on future revenues.

On June 10, 2016, the Internal Revenue Service, the Employee Benefits Security Administration, and the U.S Department of Health and Human Services, collectively “HHS,” proposed rule 2016-13583, that impacts STM insurance. On October 31, 2016, HHS published the rule, Internal Revenue Bulletin 2016-47, substantially as proposed despite opposition from significant stakeholders during the open comment period. The rule limits STM duration to periods of less than three months but allows for re-applications with the same or different health insurance carrier. The rule also requires notification of non-compliance with the minimum essential coverage standards set forth in the Affordable Care Act. The rule goes into effect on January 1, 2017 however neither HHS nor the states will enforce the rule regarding duration or renewal of STM plans until April 1, 2017. Although the rule could be the subject of repeal or further delayed enforcement due to the January 2017 change in the U.S. presidential administration, as of March 1, 2017, we were not aware of any government action or intent to repeal or delay the rule. This rule, assuming that it is enforced beginning April 1, 2017, will likely have a material impact on revenues generated from the sale of STM products beginning with our 2017 fiscal year and may also therefore have a material adverse impact on total revenues, although we are not yet able to determine the impact on total revenues, as we will seek to mitigate revenue losses by offering new products, by growing our already strong distribution channels, and by continuing our direct-to-consumer emphasis while simultaneously increasing operating leverage. There is no assurance, however, that such measures will fully offset any revenue losses associated with the implementation of the rule.

If we or our independent distributors fail to comply with the numerous laws and regulations that are applicable to our business, our business and results of operations could be harmed.

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

- grant suspend, and revoke licenses to transact insurance business;
- issue provisional or conditional licenses for probationary periods;
- conduct inquiries into the insurance-related activities and conduct of agents and agencies;
- require and regulate disclosure in connection with the sale and solicitation of health insurance;
- authorize how, by which personnel and under what circumstances insurance premiums can be quoted and published and an insurance policy can be sold;
- determine which entities can be paid commissions from carriers;
- regulate the content of insurance-related advertisements, including web pages;
- approve policy forms, require specific benefits and benefit levels and regulate premium rates;
- impose fines and other penalties;
- impose continuing education requirements on agents and employees; and
- otherwise require changes to or impose conditions on how we or our distributors conduct business in their respective jurisdictions.

Due to the complexity, periodic modification and differing interpretations of insurance laws and regulations and the number of third parties with which we have relationships, we may not have always been, and we and/or our independent distributors may not always be, in compliance with such laws and regulations. Failure to comply could result in significant liability, additional state insurance licensing requirements or the revocation of licenses in a particular jurisdiction, which could significantly reduce our revenue, increase our operating expenses, prevent us from transacting health insurance business in a particular jurisdiction and otherwise harm our business, results of operations and financial condition. Moreover, an adverse regulatory action in one jurisdiction could result in penalties and adversely affect our license status or reputation in other jurisdictions due to the requirement that adverse regulatory

actions in one jurisdiction be reported to other jurisdictions. Even if the allegations in any regulatory or other action against us are proven false, any surrounding negative publicity could harm member, distributor or health insurance carrier confidence in us, which could significantly damage our reputation. Because some members, distributors and health insurance carriers may not be comfortable with the concept of purchasing health insurance using the internet, any negative publicity may affect us more than it would others in the health insurance industry and could harm our business, results of operations and financial condition.

Because we depend in part on independent third-party distributors for the sale of our products, the failure of our distributors to comply with applicable laws and regulations could have an adverse effect on our business. For example, the actions or omissions of our independent third-party distributors could result in an investigation or regulatory action against our Company.

In addition, we have received and may in the future receive inquiries from state insurance regulators regarding our marketing and business practices and the practices of our independent third-party distributors and carriers. We may modify our practices in connection with any such inquiry, and we may require our distributors to change their practices, or we may be forced to terminate distributors. In 2016, we terminated two of our largest independent distributors for their failure to comply with our compliance standards. Any modification, or penalty for noncompliance, of our marketing or business practices in response to regulatory inquiries could harm our business, results of operations or financial condition.

For additional information regarding our current state insurance regulatory matters, see the Risk Factor above titled “Our business practices and the business practices of our third-party distributors are currently being reviewed by various state insurance regulators and the results of such reviews may adversely affect our business and results of operations” and “Legal Proceedings” in Part I, Item 3 of this report.

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

The laws and regulations governing the offer, sale and purchase of health insurance are subject to change, and future changes may be adverse to our business. For example, once health insurance pricing is set by the insurance carrier and approved by state regulators, it is fixed and not generally subject to negotiation or discounting by insurance companies or agents. Additionally, state regulations generally prohibit insurance carriers, agents and brokers from providing financial incentives, such as rebates, to their members in connection with the sale of health insurance. As a result, we do not currently compete with insurance carriers or other agents and brokers on the price of the health insurance products offered on our distribution platform. We currently base our revenue structure on various commissions and fees, including commissions from insurance premiums and enrollment, monthly administrative fees and discount benefit fees. However, future laws and regulations could negatively adjust the commissions and fees we receive. If current laws or regulations change, we could be forced to reduce prices, commissions and fees or provide rebates or other incentives for the health insurance products sold through our online platform, which could harm our business, results of operations and financial condition.

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

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

Numerous health insurance plans and products are available to individuals in any given market. Most of these plans and products vary by price, benefits and other policy features. Health insurance terminology and provisions are often confusing and difficult to understand. As a result, researching, selecting and purchasing health insurance can be a complex process. We believe that this complexity has contributed to a perception held by many individuals that individual health insurance is prohibitively expensive and difficult to obtain. If individuals are not informed about the availability and accessibility of affordable health insurance, our business may not grow and our results of operations and financial condition could be harmed.

Changes in the quality and affordability of the health insurance plans and products that insurance carriers offer to us for sale through our technology platform could harm our business and results of operations.

The demand for health insurance marketed through our technology platform is affected by, among other things, the variety, quality and price of the health insurance plans and products we offer. If health insurance carriers do not continue to allow us to sell a variety of high-quality, affordable health insurance plans and products in our markets, or if their offerings are limited or terminated as a result of consolidation in the health insurance industry, the implementation of Healthcare Reform or otherwise, our sales may decrease and our business, results of operations and financial condition could be harmed.

If we are not able to maintain and enhance our name recognition, our business and results of operations could be harmed.

We believe that maintaining and enhancing our name recognition is critical to our relationships with existing members, third-party distributors and insurance carriers and to our ability to attract new members, independent distributors and insurance carriers. The promotion of our name may require us to make substantial investments and we anticipate that, as our market becomes increasingly competitive, these marketing initiatives may become increasingly difficult. We also expect our marketing expenditures in future periods to increase. Our marketing activities may not be successful or yield increased revenue, and to the extent that these activities yield increased revenue, the increased revenue may not offset the expenses we incur and our results of operations could be harmed. If we do not successfully maintain and enhance our name recognition, our business may not grow and we could lose our relationships with insurance carriers, independent distributors or members, which could harm our business, results of operations and financial condition.

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

Our success depends in part upon continued growth in the use of the internet as a source of research on health insurance products and pricing, as well as willingness for individuals to use the internet to request further information or contact directly or indirectly the distributors that sell the products we offer. Individuals and insurance carriers may choose to depend more on traditional sources, such as individual agents, or alternative sources may develop, including as a result of Healthcare Reform. Our future growth, if any, will depend in part upon:

- the growth of the internet as a commerce medium generally, and as a market for individual health insurance plans and services specifically;

individuals' willingness and ability to conduct their own health insurance research;

our ability to make the process of purchasing health insurance online an attractive alternative to traditional and new means of purchasing health insurance;

our ability to successfully and cost-effectively market our services as superior to traditional or alternative sources for health insurance to a sufficiently large number of individuals; and

insurance carriers' willingness to use us and the internet as a distribution channel for health insurance plans and products.

If individuals and carriers determine that other sources of health insurance and health insurance applications are superior, our business will not grow and our results of operations and financial condition could be harmed.

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

We provide information on our platform, through our call center partners and in other ways regarding health insurance in general and the health insurance plans and products we market and sell, including information relating to insurance premiums, coverage, benefits, provider networks, exclusions, limitations, availability, plan and premium comparisons and insurance company ratings. A significant amount of both automated and manual effort is required to maintain the considerable amount of insurance plan information on our platform. We also regularly provide health insurance plan information in the scripts used by our customer call center partners. If the information we provide on our platform, through our customer call center partners or otherwise is not accurate or is construed as misleading, or if we do not properly assist individuals and businesses in purchasing health insurance, members, insurance carriers and others could attempt to hold us liable for damages, our relationships with insurance carriers could be terminated and regulators could attempt to subject us to penalties, revoke our licenses to transact health insurance business in a particular jurisdiction, and/or compromise the status of our licenses to transact health insurance business in other jurisdictions, which could result in our loss of our commission revenue. In the ordinary course of operating our business, we have received complaints that the information we provided was not accurate or was misleading. Although in the past we have resolved these complaints without significant financial cost, we cannot guarantee that we will be able to do so in the future. In addition, these types of claims could be time-consuming and expensive to defend, could divert our management's attention and other resources and could cause a loss of confidence in our services. As a result, these types of claims could harm our business, results of operations and financial condition. Additionally, we are subject to various federal and state telemarketing regulations, including the Telephone Consumer Protection Act ("TCPA") and the FCC's implementing regulations, as well as various state telemarketing laws and regulations. We, our distributors, and our carriers have been, and may continue to be, the subject of allegations of TCPA violations, and we could be responsible for some of the costs incurred by distributors or carriers who are the subject of allegations of TCPA violations. Any violation of these regulations could expose us to damages for monetary loss, statutory damages, fines, penalties and/or regulatory inquiries.

In the ordinary course of our business, we have received, and may continue to receive, inquiries from state regulators relating to various matters or in the future become involved in litigation. Also from time to time, we may be a party to litigation and subject to civil claims incident to the ordinary course of business, including claims from consumers alleging misrepresentation and material omissions in connection with their purchase of our products. For information regarding our current regulatory matters, see the Risk Factor above titled “Our business practices and the business practices of our third-party distributors are currently being reviewed by various state insurance regulators and the results of such reviews may adversely affect our business and results of operations” and “Legal Proceedings” in Part I, Item 3 of this report. If we are found to have violated laws or regulations, we could lose our relationship with insurance carriers and be subject to various fines and penalties, including revocation of our licenses to sell insurance, and our business, results of operations and financial condition would be materially harmed. We could also be harmed to the extent that related publicity damages our reputation as a trusted source of information relating to health insurance and its affordability. It could also be costly to defend ourselves regardless of the outcome. As a result, inquiries from regulators or our becoming involved in litigation could adversely affect our business, results of operations and financial condition.

If we do not continue to attract new individual customers, we may not achieve our revenue and premium equivalents projections, and our results of operations could be harmed.

In order to grow our business, we must continually attract new independent distributors and individual customers. Our ability to do so depends in large part on the success of our sales and marketing efforts. Potential individual customers may seek out other options for purchasing insurance. Therefore, we must demonstrate that our products provide a viable solution for individual customers to obtain high quality coverage at an attractive price and provide a valuable business opportunity to our distributors. If we fail to provide high quality solutions and convince individual customers and independent distributors of our value proposition, we may not be able to retain existing customers or attract new individual customers. Additionally, there is no guarantee that the market for our services will grow as we expect. If the market for our services declines or develops more slowly than we expect, or if the number of individual customers or third-party distributors that use our solutions declines or fails to increase as we expect, our revenue, premium equivalents, results of operations, financial condition, business and prospects could be harmed.

Advance commission arrangements between us and some of our third-party distributors expose us to the credit risks of such distributors, which could in turn have an adverse effect on our business, financial condition, and results of operations.

We make advance commission payments to many of our independent distributors in order to assist them with the cost of lead acquisition and provide working capital. As of December 31, 2016, we had a balance outstanding for advanced commissions of approximately $37.0 million under such arrangements of which approximately $32.6 million is with three distributors. Of the three, one distributor accounts for approximately $24.1 million, or 65.2% of the total outstanding balance. In most cases where we make advance commission payments, we receive security interests in collateral, as well as personal and entity-level guarantees. At a minimum, our collateral includes a claim against all future compensation owed to the distributor for all products sold. As a result, our claims for such payments would usually be considered secured claims. Depending on the amount of future compensation owed to the distributor, we could be exposed to the credit risks of our third-party distributors in the event of their insolvency or bankruptcy. Where the amount owed to us exceeds the value of the collateral, our claims against the defaulting distributors would rank below those of certain other secured creditors, which could undermine our chances of obtaining the return of our advance commission payments. We may not be able to recover such advance payments and we may suffer losses should the independent distributors fail to fulfill their sales obligations under the contracts. Accordingly, any of the above scenarios could harm our business, results of operations and financial condition.

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Seasonality could cause fluctuations in our financial results.

Our business of marketing IFP and supplemental plans is subject to seasonal fluctuations that we believe have been impacted by Healthcare Reform. Under Healthcare Reform, the PPACA open enrollment period begins in the fourth quarter of 2016 and continues into the first quarter of 2017, at which time individuals can enroll in ACA compliant individual insurance programs. During the times that the open enrollment period is closed, we have the capability to sell our IFP products as an alternative health insurance option for consumers who are ineligible for plans offered by PPACA. Other seasonality trends may develop and the existing seasonality and consumer behavior that we have experienced may change as the implementation and enforcement of Healthcare Reform continues and our markets continue to change. Any seasonality that we experience could cause fluctuations in our financial results.

If we are unable to successfully introduce new technology solutions or services or fail to keep pace with advances in technology, our business, financial condition and results of operations could be adversely affected.

Our business depends on our ability to adapt to evolving technologies and industry standards and introduce new technology solutions and services accordingly. If we cannot adapt to changing technologies, our technology solutions and services may become obsolete, and our business would suffer. Because the healthcare insurance market is constantly evolving, our existing technology may become obsolete and fail to meet the requirements of current and potential members. Our success will depend, in part, on our ability to continue to enhance our existing technology

solutions and services, develop new technology that addresses the increasingly sophisticated and varied needs of our members and respond to technological advances and emerging industry standards and practices on a timely and cost-effective basis. The development of our online platform entails significant technical and business risks. We may not be successful in developing, using, marketing, or maintaining new technologies effectively or adapting our technology to evolving customer requirements or emerging industry standards, and, as a result, our business and reputation could suffer. We may not be able to introduce new technology solutions on schedule, or at all, or such solutions may not achieve market acceptance. We also engage third-party vendors to develop, maintain and enhance our technology solutions, and our ability to develop and implement new technologies is therefore dependent on our ability to engage suitable vendors. We may also need to license software or technology from third parties in order to maintain, expand or modify our technology platform. However, there is no guarantee we will be able to enter into such agreements on acceptable terms or at all. Moreover, competitors may develop competitive products that could adversely affect our results of operations. A failure by us to introduce new solutions or to introduce these solutions on schedule could have an adverse effect on our business, financial condition and results of operations.

Our failure to obtain, maintain and enforce the intellectual property rights on which our business depends could have a material adverse effect on our business, financial condition and results of operations.

We rely upon intellectual property laws in the United States, and non-disclosure, confidentiality and other types of agreements with our employees, members and other parties, to establish, maintain and enforce our intellectual property and proprietary rights. However, any of our owned or licensed intellectual property rights could be challenged, invalidated, circumvented, infringed or misappropriated, our trade secrets and other confidential information could be disclosed in an unauthorized manner to third-parties, or our intellectual property rights may not be sufficient to permit us to take advantage of current market trends or otherwise to provide us with competitive advantages, which could result in costly redesign efforts, discontinuance of certain offerings or other competitive harm. Efforts to enforce our intellectual property rights may be time consuming and costly, distract management’s attention and resources and ultimately be unsuccessful. In addition, such efforts may result in our intellectual property rights being challenged, limited in scope, or declared invalid or unenforceable. Moreover, our failure to develop and properly manage new intellectual property could adversely affect our market positions and business opportunities.

We may not be able to obtain, maintain and enforce the intellectual property rights that may be necessary to protect and grow our business and to provide us with a meaningful competitive advantage. Also, some of our business and services may rely on technologies and software developed by or licensed from third-parties, and we may not be able to maintain our relationships with such third-parties or enter into similar relationships in the future on reasonable terms or at all. Our failure to obtain, maintain and enforce our intellectual property rights could therefore have a material adverse effect on our business, financial condition and results of operations.

Assertions by third-parties that we violate their intellectual property rights could have a material adverse effect on our business, financial condition and results of operations.

Third-parties may claim that we, our members, our licensees or parties indemnified by us are infringing upon or otherwise violating their intellectual property rights. Such claims may be made by competitors seeking to obtain a competitive advantage or by other parties. Additionally, in recent years, individuals and groups have begun purchasing intellectual property assets for the purpose of making claims of infringement and attempting to extract settlements from companies like ours. Any claims that we violate a third-party's intellectual property rights can be time consuming and costly to defend and distract management's attention and resources, even if the claims are without merit. Such claims may also require us to redesign affected products and services, enter into costly settlement or license agreements or pay costly damage awards, or face a temporary or permanent injunction prohibiting us from marketing or providing the affected products and services. Even if we have an agreement entitling us to indemnity against such costs, the indemnifying party may be unable to uphold its contractual obligations. If we cannot or do not license the infringed technology at all, license the technology on reasonable terms or substitute similar technology from another source, our revenue and earnings could be adversely impacted.

In addition, we may use open source software in connection with our products and services. Companies that incorporate open source software into their products have, from time to time, faced claims challenging the ownership of open source software and/or compliance with open source license terms. As a result, we could be subject to suits by parties claiming ownership of what we believe to be open source software or noncompliance with open source licensing terms. Some open source software licenses require users who distribute open source software as part of their software to publicly disclose all or part of the source code to such software and/or make available any derivative works of the open source code on unfavorable terms or at no cost. Any requirement to disclose our proprietary source code or pay damages for breach of contract could have a material adverse effect on our business, financial condition and results of operations.

Assertions by third-parties that we violate their intellectual property rights could therefore have a material adverse effect on our business, financial condition and results of operations.

If we fail to effectively manage our growth, our business and results of operations could be harmed.

We have expanded our operations significantly since 2008. This has significantly increased the demands on our management, our operational and financial systems and infrastructure and other resources. If we do not effectively manage our growth, the quality of our services could suffer. In order to successfully expand our business, we must effectively integrate, develop and motivate new employees, and we must maintain the beneficial aspects of our corporate culture. We may not be able to hire new employees quickly enough to meet our needs. If we fail to effectively manage our hiring needs and successfully integrate our new hires, our efficiency and ability to meet our forecasts and our employee morale, productivity and retention could suffer, and our business and results of operations

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

If we are unable to maintain a high level of service, our business and prospects could be harmed.

One of the key attributes of our business is providing high quality service to our insurance carriers, distributors and members. We may be unable to sustain these levels of service, which would harm our reputation and our business. Alternatively, we may only be able to sustain high levels of service by significantly increasing our operating costs, which would materially adversely affect our results of operations. The level of service we are able to provide depends on our personnel to a significant extent. Our personnel must be well-trained in our processes and able to handle customer calls effectively and efficiently. Any inability of our personnel to meet our demand, whether due to absenteeism, training, turnover, disruptions at our facilities, bad weather, power outages or other reasons, could adversely impact our business. If we are unable to maintain high levels of service performance, our reputation could suffer and our results of operations and prospects could be harmed.

We are subject to privacy and data protection laws governing the transmission, security and privacy of health information, which may impose restrictions on the manner in which we access personal data and subject us to penalties if we are unable to fully comply with such laws.

Numerous federal, state and international laws and regulations govern the collection, use, disclosure, storage and transmission of individually identifiable health information. These laws and regulations, including their interpretation by governmental agencies, are subject to frequent change. These regulations could have a negative impact on our business, for example:

HIPAA and its implementing regulations were enacted to ensure that employees can retain and at times transfer their health insurance when they change jobs, and to simplify healthcare administrative processes. The enactment of HIPAA also expanded protection of the privacy and security of personal health information and required the adoption of standards for the exchange of electronic health information. Among the standards that the Department of Health and Human Services has adopted pursuant to HIPAA are standards for electronic transactions and code sets, unique identifiers for providers, employers, health plans and individuals, security, electronic signatures, privacy and enforcement. Failure to comply with HIPAA could result in fines and penalties that could have a material adverse effect on us.

The HITECH Act sets forth health information security breach notification requirements and increased penalties for violation of HIPAA. The HITECH Act requires individual notification for all breaches, media notification of breaches of over 500 individuals and at least annual reporting of all breaches to the Department of Health and Human Services. The HITECH Act also replaced the prior penalty system of one tier of penalties of $100 per violation and an annual maximum of $25,000 with a four-tier system of sanctions for breaches. Penalties now range from the original $100 per violation and an annual maximum of $25,000 for the first tier to a fourth-tier minimum of $50,000 per violation and an annual maximum of $1.5 million. Failure to comply with the HITECH Act could result in fines and penalties that could have a material adverse effect on us.

Other federal and state laws restricting the use and protecting the privacy and security of individually identifiable information may apply, many of which are not preempted by HIPAA.

Federal and state consumer protection laws are increasingly being applied by the FTC, and states' attorneys general to regulate the collection, use, storage and disclosure of personal or individually identifiable information, through websites or otherwise, and to regulate the presentation of website content.

We are required to comply with federal and state laws governing the transmission, security and privacy of individually identifiable health information that we may obtain or have access to in connection with the provision of our services. Despite the security measures that we have in place to ensure compliance with privacy and data protection laws, our facilities and systems, and those of our third-party vendors and subcontractors, are vulnerable to security breaches, acts of vandalism or theft, computer viruses, misplaced or lost data, programming and human errors or other similar events. Due to the recent enactment of the HITECH Act, we are not able to predict the extent of the impact such incidents may have on our business. Our failure to comply may result in criminal and civil liability because the potential for enforcement action against business associates is now greater. Enforcement actions against us could be costly and could interrupt regular operations, which may adversely affect our business. While we have received

inquiries relating to our compliance with various privacy acts, including inquiries originating from allegations of a potential breach, to date none have been found or determined to be actual violations by our Company.

Under the HITECH Act, as a business associate we may also be directly or independently liable for privacy and security breaches and failures of our subcontractors. Even though we provide for appropriate protections through our agreements with our subcontractors, we still have limited control over their actions and practices. A breach of privacy or security of individually identifiable health information by a subcontractor may result in an enforcement action, including criminal and civil liability, against us. In addition, numerous other federal and state laws protect the confidentiality of individually identifiable information as well as employee personal information, including state medical privacy laws, state social security number protection laws, and federal and state consumer protection laws. These various laws in many cases are not preempted by HIPAA and may be subject to varying interpretations by the courts and government agencies, creating complex compliance issues for us and our members and potentially exposing us to additional expense, adverse publicity and liability, any of which could adversely affect our business.

Our business is subject to online security risks, and if we are unable to safeguard the security and privacy of confidential data, our reputation and business could be harmed.

Our services involve the collection and storage of confidential information of members and the transmission of this information to insurance carriers. For example, we collect names, addresses, and social security, bank account and credit card numbers, as well as information regarding the medical history of members in connection with their applications for insurance. In certain cases such information is provided to third-parties, for example to the service providers who provide hosting services for our technology platform, and we may therefore be unable to control the use of such information or the security protections employed by such third-parties. We may be required to expend significant capital and other resources to protect against security breaches or to alleviate problems caused by security breaches. Despite our implementation of security measures, techniques used to obtain unauthorized access or to sabotage systems change frequently. As a result, we may be unable to anticipate these techniques or to implement adequate preventative measures. Any compromise or perceived compromise of our security (or the security of our third-party service providers who have access to our members' confidential information) could damage our reputation and our relationship with our members, third-party distributors and insurance carriers, could reduce demand for our services and could subject us to significant liability as well as regulatory action. In addition, in the event that new data security laws are implemented, or our insurance carriers or other partners determine to impose new requirements on us relating to data security, we may not be able to timely comply with such requirements, or such requirements may not be compatible with our current processes. Changing our processes could be time consuming and expensive, and failure to timely implement required changes could result in our inability to sell health insurance plans and products in a particular jurisdiction or for a particular insurance carrier, or subject us to liability for non-compliance.

Our services present the potential for embezzlement, identity theft or other similar illegal behavior by our employees or subcontractors with respect to third-parties.

Among other things, our services involve handling information from members, including credit card information and bank account information. Our services also involve the use and disclosure of personal information that could be used to impersonate third-parties or otherwise gain access to their data or funds. If any of our employees or subcontractors takes, converts or misuses such funds, documents or data, we could be liable for damages, and our business reputation could be damaged. In addition, we could be perceived to have facilitated or participated in illegal misappropriation of funds, documents or data and therefore be subject to civil or criminal liability. Any such illegal activity by our employees or subcontractors could have an adverse effect on our business, financial condition and results of operations.

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

The performance, reliability and availability of our technology platform, customer service call center and underlying network infrastructures are critical to our financial results and our relationship with members, independent distributors and insurance carriers. Although we regularly attempt to enhance and maintain our technology platform, customer service call center and system infrastructure, system failures and interruptions may occur if we are unsuccessful in these efforts or experience difficulties with transitioning existing systems to upgraded systems, if we are unable to accurately project the rate or timing of increases in our platform traffic or customer service call center call volume or for other reasons, some of which are completely outside our control. Significant failures and interruptions, particularly during peak enrollment periods, could harm our business, results of operations and financial condition.

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

We depend upon third parties, including telephone service providers, third-party software providers and business process outsourcing providers, to operate our customer service call center. Any failure of the systems upon which we rely in the operation of our customer service call center could negatively impact sales as well as our relationship with members, which could harm our business, results of operations and financial condition.

Insurance carriers and distributors depend upon third-party service providers to access our online platform, and our business and results of operations could be harmed as a result of technical difficulties experienced by these service providers.

Insurance carriers and distributors using our online platform depend upon internet and other service providers for access to our platform. Many of these service providers have experienced significant outages, delays and other difficulties in the past and could experience them in the future. Any significant interruption in access to our technology platform or increase in our platform's response time as a result of these difficulties could damage our relationship with insurance carriers, third-party distributors and existing and potential members and could harm our business, results of operations and financial condition.

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

Our revenue depends upon demand for our insurance products, which can be influenced by a variety of factors beyond our control. We have no control over the economic and other factors that influence such demand. Any softening of demand for our products and the services offered by us, whether caused by changes in individual preferences or the regulated environment in which we operate, or by a weak economy, will result in decreased revenue and growth. Members may attempt to reduce expenses by canceling existing plans and products purchased through us, not purchasing new plans and products through us or purchasing plans with lower premiums for which we receive lower commissions. A negative economic environment could also adversely impact the insurance carriers whose plans and products are offered on our platform, and they may, among other things, determine to reduce their commission rates, increase premiums or reduce benefits, any of which could negatively impact our business, results of operations and financial condition.

To the extent the economy or other factors adversely impact our member retention, the number or type of insurance applications submitted through us and that are approved by insurance carriers, or the commissions that we receive from insurance carriers, our rate of growth will decline and our business and results of operations will be harmed.

The loss of any member of our management team and our inability to make up for such loss with a qualified replacement could harm our business.

Competition for qualified management in our industry is intense. Many of the companies with which we compete for management personnel have greater financial and other resources than we do or are located in geographic areas which may be considered by some to be more desirable places to live. If we are not able to retain any of our key management personnel, our business could be harmed.

Our acquisitions and other strategic transactions may be difficult to integrate, divert management resources, result in unanticipated costs or dilute our stockholders.

Part of our continuing business strategy is to acquire or invest in, companies, products or technologies that complement our current products, enhance our market coverage, technical capabilities or production capacity, or offer growth opportunities or make other strategic transactions. Such transactions could pose numerous risks to our operations, including:

- difficulty integrating the purchased operations, technologies or products;
- incurring substantial unanticipated integration costs;
- assimilating the acquired businesses may divert significant management attention and financial resources from our other operations and could disrupt our ongoing business;
- acquisitions could result in the loss of key employees, particularly those of the acquired operations;
- difficulty retaining or developing the acquired businesses' customers;
- acquisitions could adversely affect our existing business relationships with suppliers and members;
- failing to realize the potential cost savings or other financial benefits and/or the strategic benefits of the acquisitions; and
- incurring liabilities from the acquired businesses for infringement of intellectual property rights or other claims, and we may not be successful in seeking indemnification for such liabilities or claims.

In connection with these acquisitions or investments, we could incur debt, amortization expenses related to intangible assets, large and immediate write-offs, assume liabilities or issue stock that would dilute our current stockholders' percentage of ownership. We may not be able to complete acquisitions or integrate the operations, products or personnel gained through any such acquisition without a material adverse effect on our business, financial condition

and results of operations.

We may not be able to successfully recognize anticipated acquisition synergies or retain key acquisition employees

The long-term success of the HP acquisition, which we completed in July 2014, depends on our continued ability to leverage the assets, resources and personnel of HP to design and develop our direct to consumer platform, AgileHealthInsurance®, to expand our business and increase our profitability. In order to successfully achieve this, we will need to integrate, motivate, and retain current and new HP employees. Many of these employees are based in Silicon Valley, the location of HP's offices, and recruiting and retaining top employees in Silicon Valley is very challenging because it is a competitive employment market. This will place significant demands on our management, our operational and financial systems, our infrastructure, and our other resources. If we do not effectively manage this process, our ability to develop new products and grow the consolidated business in the manner anticipated by the acquisition will suffer.

AgileHealthInsurance® depends upon marketing partnerships to attract a significant portion of the consumers who visit our website, and Agile's success is dependent on our ability to maintain effective relationships with our existing marketing partners and establish successful relationships with new marketing partners

We enter into contractual marketing relationships with online and offline businesses that promote AgileHealthInsurance® to its customers and users. These marketing partners include online advertisers, content providers and insurance lead aggregators, and we typically compensate our marketing partners for their online referrals (clickthroughs) on a performance basis (CPA or CPC). If we are unable to maintain successful relationships with our existing marketing partners or fail to establish successful relationships with new marketing partners, our business, results of operations and financial condition will be harmed. Additionally, if competition increases with respect to marketing partner relationships, this would increase the cost of compensation agreements with marketing partners and increase the marketing expenses associated with these partners.

AgileHealthInsurance® depends upon internet search engines to attract a significant portion of the consumers who visit our direct to consumer website

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

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

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

The success of our direct to consumer channel depends on the continuation of private health insurance plans available for consumer purchase

Our ability to attract consumer traffic to and generate member interest for AgileHealthInsurance® is predicated on a health insurance market where consumers have the need for private health insurance and have a plurality of options from which to choose. Should the government regulations reduce or eliminate the availability of health insurance

plans provided by private commercial entities then our ability to produce online direct to consumer sales could be jeopardized.

The requirements of being a public company impose costs and demands upon our management, which could make it difficult to manage our business, particularly after we are no longer an "emerging growth company."

Complying with the reporting and other regulatory requirements of the Securities Exchange Act of 1934 (as amended, the "Exchange Act") and the requirements of the Sarbanes-Oxley Act of 2002 (as amended, the "Sarbanes-Oxley Act") is time-consuming and costly and could have a negative effect on our business, financial condition and results of operations. The Exchange Act requires that we file annual, quarterly and current reports with respect to our business and financial condition. The Sarbanes-Oxley Act requires that we maintain effective disclosure controls and procedures and internal controls over financial reporting. To maintain and improve the effectiveness of our disclosure controls and procedures and internal control over financial reporting, we have committed significant resources, hired additional staff and provided additional management oversight. We expect these resources and management oversight requirements to continue. These activities may divert management's attention from other business concerns, which could have a material adverse effect on our business, financial condition and results of operations.

As an "emerging growth company" as defined in the Jumpstart Our Business Startups Act of 2012 (the "JOBS Act"), we benefit from certain temporary exemptions from various reporting requirements, including, but not limited to, not being required to comply with the auditor attestation requirements of Section 404 of the Sarbanes-Oxley Act and reduced disclosure obligations regarding executive compensation in our periodic reports and proxy statements. In addition, we have elected under the JOBS Act to delay adoption of new or revised accounting pronouncements applicable to public companies until such pronouncements are made applicable to private companies. When these exemptions cease to apply, we expect to incur additional expenses and devote increased management effort toward ensuring compliance with them. We cannot predict or estimate the amount of additional costs we may incur as these exemptions cease to apply.

Risks Related to Our Structure

We are a holding company and our only material asset is our interest in HPIH and, accordingly, we are dependent upon distributions from HPIH to pay taxes and other expenses.

We are a holding company and have no material assets other than our ownership of Series A Membership Interests of HPIH. We have no independent means of generating revenue. HPIH is treated as a partnership for U.S. federal income tax purposes and, as such, is not itself subject to U.S. federal income tax. Instead, its net taxable income is generally allocated to its members, including us, *pro rata* according to the number of Membership Interests each member owns. Accordingly, we incur income taxes on our proportionate share of any net taxable income of HPIH and also incur expenses related to our operations. We intend to cause HPIH to distribute cash to its members, including us, in an amount at least equal to the amount necessary to cover their respective tax liabilities, if any, with respect to their allocable share of the net income of HPIH and to cover dividends, if any, declared by us, as well as any payments due under the tax receivable agreement, as described below. To the extent that we need funds to pay our tax or other liabilities or to fund our operations, and HPIH is restricted from making distributions to us under applicable agreements, laws or regulations or does not have sufficient cash to make these distributions, we may have to borrow funds to meet these obligations and operate our business, and our liquidity and financial condition could be materially adversely affected. To the extent that we are unable to make payments under the income tax receivable agreement for any reason, such payments will be deferred and will accrue interest until paid.

We will be required to pay the existing and potential future holders of Series B Membership Interests of HPIH most of the tax benefits that we may receive as a result of any future exchanges of Series B Membership Interests for our Class A common stock and payments made under the tax receivable agreement itself, and the amounts we pay could be substantial.

We expect that any future exchanges of Series B Membership Interests (together with an equal number of shares of our Class B common stock) for shares of our Class A common stock will result in increases in the tax basis in our share of the tangible and intangible assets of HPIH. Any such increases in tax basis could reduce the amount of tax

that we would otherwise be required to pay in the future.

We have entered into a tax receivable agreement with entities that hold Series B Membership Interests that are beneficially owned by Michael W. Kosloske, our founder, pursuant to which we will pay them 85% of the amount of the cash savings, if any, in U.S. federal, state and local income tax that we realize (or are deemed to realize in the case of an early termination payment by us, a change in control or a material breach by us of our obligations under the tax receivable agreement, as discussed below) as a result of these possible increases in tax basis resulting from exchanges of Series B Membership Interests as well as certain other benefits attributable to payments under the tax receivable agreement itself. Any actual increases in tax basis, as well as the amount and timing of any payments under the tax receivable agreement, cannot be predicted reliably at this time. The amount of any such increases and payments will vary depending upon a number of factors, including the timing of exchanges, the price of our Class A common stock at the time of the exchanges, the amount, character and timing of our income and the tax rates then applicable. The payments that we may be required to make pursuant to the tax receivable agreement could be substantial for periods in which we generate taxable income. Changes in factors such as the corporate income tax rate or our ability to generate taxable income in the future could impact our valuation allowance for the deferred tax asset resulting in a benefit or a charge during the period.

In addition, the tax receivable agreement provides that in the case that we exercise our right to early termination of the tax receivable agreement or in the case of a change in control or a material breach by us of our obligations under the tax receivable agreement, the tax receivable agreement will terminate, and we will be required to make a payment equal to the present value of future payments under the tax receivable agreement, which payment would be based on certain assumptions, including those relating to our future taxable income. In these situations, our obligations under the tax receivable agreement could have a substantial negative impact on our liquidity and could have the effect of delaying, deferring or preventing certain mergers, asset sales, other forms of business combinations or other changes of control. These provisions of the tax receivable agreement may result in situations where Mr. Kosloske may have interests that differ from or are in addition to those of our stockholders.

We may not be able to realize all or a portion of the tax benefits that are expected to result from future exchanges of Series B Membership Interests for our Class A common stock and payments made under the tax receivable agreement itself.

Our ability to benefit from any depreciation or amortization deductions or to realize other tax benefits that we currently expect to be available as a result of the increases in tax basis created by future exchanges of Series B Membership Interests (together with an equal number of shares of our Class B common stock) for our Class A common stock, and our ability to realize certain other tax benefits attributable to payments under the tax receivable agreement itself depend on a number of assumptions, including that we earn sufficient taxable income each year during the period over which such deductions are available and that there are no adverse changes in applicable law or regulations. If our actual taxable income were insufficient and/or there were adverse changes in applicable law or regulations, we may be unable to realize all or a portion of these expected benefits and our cash flows and stockholders' equity could be negatively affected.

If the Internal Revenue Service successfully challenges the tax basis increases, we will not be reimbursed for any payments made under the tax receivable agreement (although future payments under the tax receivable agreement, if any, would be adjusted to reflect the result of any such successful challenge by the Internal Revenue Service). As a result, in certain circumstances, we could be required to make payments under the tax receivable agreement in excess of our cash tax savings.

Risks Related to Ownership of Our Class A Common Stock

We expect that our stock price will fluctuate significantly, and you may not be able to resell your shares at or above the purchase price.

We completed our IPO in February 2013. From that time through December 31, 2016, shares of our Class A common stock have traded between a low of $3.72 per share to a high of $19.30 per share. Several entities have reported owning, as of December 31, 2016, substantial portions of our Class A common stock. An active, liquid and orderly market for our Class A common stock may not be sustained, which could depress the market price of our Class A common stock and cause you to have difficulty selling any shares of our Class A common stock that you purchase at or above the price you paid or at all. In the future, the market price of our Class A common stock may be highly volatile and trading volumes may be low and could be subject to wide price fluctuations in response to various factors, including:

- market conditions in the broader stock market in general, or in our industry in particular;

actual or anticipated fluctuations in our quarterly financial and results of operations;

our ability to satisfy our ongoing capital needs and unanticipated cash requirements;

additional indebtedness incurred in the future;

introduction of new products and services by us or our competitors;

issuance of new or changed securities analysts' reports or recommendations;

sales of large blocks of our stock;

additions or departures of key personnel;

regulatory developments;

litigation and governmental investigations; and

economic and political conditions or events.

These and other factors may cause the market price and demand for our Class A common stock to fluctuate substantially, which may limit or prevent investors from readily selling their shares of Class A common stock and may otherwise negatively affect the liquidity of our Class A common stock. In addition, in the past, when the market price of a stock has been volatile, holders of that stock have often instituted securities class action litigation against the company that issued the stock. If any of our stockholders brought a lawsuit against us, we could incur substantial costs defending the lawsuit. Such a lawsuit could also divert the time and attention of our management from our business.

The trading market for our Class A common stock may also be influenced by the research and reports that industry or securities analysts publish about us or our business. If one or more of these analysts cease coverage of our Company or fail to publish reports on us regularly, we could lose visibility in the financial markets, which in turn could cause our stock price or trading volume to decline. Moreover, if one or more of the analysts who cover us downgrades our stock, or if our results of operations do not meet their expectations, our stock price could decline.

The market price of our Class A common stock could decline due to future sales, or expected sales, of converted shares of Class A common stock, whether upon the exchange of Series B Membership Interests by our founder and largest stockholder or upon exercise of stock appreciation rights granted to employees and directors.

The market price of our Class A common stock could decline as a result of sales, or the possibility of sales, of a large number of shares of our Class A common stock eligible for future sale upon the exchange of Series B Membership Interests of HPIH (together with an equal number of shares of our Class B common stock) or upon the exercise of stock appreciation rights. These sales, or the perception that the sales may occur, may also make it more difficult for us to raise additional capital by selling equity securities in the future at a time and price that we deem appropriate. As of March 1, 2017, 6,841,667 Series B Membership Interests were outstanding and held by entities owned by Michael Kosloske, our founder and largest stockholder. As required by a registration rights agreement between the Company and Mr. Kosloske's affiliate entities, there is an effective registration statement covering the resale of Class A common stock that is issuable in exchange for the Series B Membership Interests owned by Mr. Kosloske's affiliates, although the holders of the interests are under no obligation to effectuate exchanges and resell the shares they receive. Under the registration rights agreement, Mr. Kosloske has the right, among other things, to sell the shares covered by the effective registration statement in an underwritten offering and to require the Company to provide assistance in connection with any such offering, such as by filing one or more prospectus supplements. In addition to the shares held by Mr. Kosloske's affiliated entities, as of March 1, 2017, there were approximately 353,000 outstanding stock appreciation rights held by our directors and executive officers that are exercisable for shares of our Class A common stock.

Some provisions of Delaware law, our amended and restated certificate of incorporation and amended and restated bylaws and the beneficial ownership of a majority of our shares by one person may deter third-parties from acquiring us.

Our amended and restated certificate of incorporation and amended and restated bylaws provide for, among other things:

- restrictions on the ability of our stockholders to fill a vacancy on the board of directors;
- prohibit stockholder action by written consent;
- prohibit cumulative voting in the election of directors, which would otherwise allow holders of less than a majority of stock to elect some directors;
- provide that special meetings of stockholders may be called only by the board of directors, the chairman of the board of directors or the chief executive officer;
- establish advance notice procedures for the nomination of candidates for election as directors or for proposing matters that can be acted upon at stockholder meetings;

directors may be removed only for cause and only upon the affirmative vote of holders of at least 75% of all of the outstanding shares of our capital stock entitled to vote

certain provisions of our amended and restated certificate of incorporation may only be amended upon the affirmative vote of holders of at least 75% of all of the outstanding shares of our capital stock entitled to vote; and

the authorization of undesignated preferred stock, the terms of which may be established and shares of which may be issued without stockholder approval.

These anti-takeover defenses, the beneficial ownership of a majority of our shares by one person and other factors could discourage, delay or prevent a transaction involving a change in control of our Company. These provisions could also discourage proxy contests and make it more difficult for our stockholders to elect directors of their choosing and cause us to take other corporate actions that our stockholders desire.

We do not anticipate paying any cash dividends in the foreseeable future.

We currently intend to retain our future earnings, if any, for the foreseeable future to fund the development and growth of our business. We do not intend to pay any dividends to holders of our Class A common stock. As a result, capital appreciation in the price of our Class A common stock, if any, will be your only source of gain on an investment in our Class A common stock.

Our internal control over financial reporting may not be effective in the future, and our independent registered public accounting firm may not be able to certify as to its effectiveness, which could have a significant and adverse effect on our business and reputation.

If we fail in the future to achieve and maintain the adequacy of our internal controls, as such standards are modified, supplemented or amended from time to time, we may not be able to conclude, on an ongoing basis, that we have effective internal control over financial reporting in accordance with Section 404 of the Sarbanes-Oxley Act. If we are not able to comply with the requirements of Section 404 of the Sarbanes-Oxley Act, we may be subject to sanctions or investigation by regulatory authorities, such as the SEC. As a result, there could be a negative reaction in the financial markets due to a loss of confidence in the reliability of our financial statements. In addition, we may be required to incur costs in improving our internal control system and the hiring of additional personnel. Any such action could negatively affect our results of operations and cash flows.

We are an "emerging growth company" and we cannot be certain if the reduced disclosure requirements applicable to emerging growth companies will make our Class A common stock less attractive to investors.

We are an "emerging growth company," and we benefit from certain exemptions from various reporting requirements that are applicable to other public companies that are not "emerging growth companies" including, but not limited to, not being required to comply with the auditor attestation requirements of Section 404 of the Sarbanes-Oxley Act, which may increase the risk that weaknesses or deficiencies in our internal control over financial reporting go undetected, and reduced disclosure obligations regarding executive compensation in our periodic reports and proxy statements, which may make it more difficult for investors and securities analysts to evaluate our Company. In addition, we have elected under the JOBS Act to delay adoption of new or revised accounting pronouncements applicable to public companies until such pronouncements are made applicable to private companies. As a result of this election, our financial statements may not be comparable to companies that comply with public company effective dates. If some investors find our Class A common stock less attractive as a result, there may be a less active trading market for our Class A common stock and our stock price may be more volatile. We may take advantage of these reporting exemptions until we are no longer an "emerging growth company," which in certain circumstances could be up to five years.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

As of December 31, 2016, we leased facilities in four different cities throughout the U.S. All properties are leased with various expiration dates. Our locations are summarized as follows:

Location	Approximate Square Footage	Type of Interest	Expiration of lease
Tampa, FL	15,700	Leased	December 2019
Mountain View, CA	1,100	Leased	October 2018
Waxahachie, TX	2,000	Leased	December 2017
Haltom City, TX	3,300	Leased	Month-to-month

We believe that our properties are generally in good condition, well maintained and suitable and adequate to carry out our business at expected capacity for the foreseeable future. Should additional capacity become necessary in the future, we believe that suitable additional or alternative space will be available on commercially reasonable terms to

accommodate our foreseeable future expansion.

ITEM 3. LEGAL PROCEEDINGS

We are currently a party to multiple litigation proceedings. From time to time, we may be a party to litigation and subject to claims incident to the ordinary course of business, including claims from consumers alleging misrepresentation and material omissions in connection with their purchase of our products. Regardless of the outcome, litigation can have an adverse impact on us because of defense and settlement costs, diversion of management resources and other factors.

State Regulatory Examinations

From time to time the Company receives information and document requests from state insurance regulators concerning the business practices of the Company and/or third-party distributors of the Company's products. The Company's policy is to proactively communicate and cooperate with all such requests.

Indiana Multistate Market Conduct Examination

The Company received notification in April 2016 from the Indiana Department of Insurance that a multistate examination had been commenced providing for the review of HCC Life Insurance Company's ("HCC") short-term medical plans, Affordable Care Act compliance, marketing, and rate and form filing for all products. In May 2016, the Company received notice that the Market Actions Working Group of the National Association of Insurance Commissioners determined that the examination would become a multistate examination. As the Company was a distributor of HCC products at that time, the notification indicated that the multistate examination will include a review of the activities of the Company and a review of whether the Company's practices are in compliance with Indiana insurance law and the similar laws of other states participating in the examination. The Indiana Department of Insurance is serving as the managing participant of the multistate examination, and the examination includes, among other things, a review of whether HCC (and the Company) has engaged in any unfair or deceptive acts or insurance business practices. At present, forty-two states have joined the multistate examination. On June 1, 2016, the Company responded to an initial document production request in this matter. In addition to the multistate examination led by Indiana, we are aware that several other states, including Florida, Ohio, and South Dakota are reviewing the sales practices and potential unlicensed sale of insurance by third-party distributor call centers utilized by the Company. The Company is not aware of any examination into the sales practices of the Company-owned call center, although the Company cannot be certain that no such investigation is occurring or will occur, and the Company is aware of and managing additional claims and inquiries that it does not believe are material at this time. Except as otherwise described below, it is too early to determine whether any of these regulatory examinations will have a material impact on the Company. The Company is proactively communicating and cooperating with all applicable regulatory agencies, and has provided a detailed action plan to regulators that summarizes the Company's newly developed and enhanced compliance and control mechanisms.

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Montana Regulatory Action

The Company also received notification from the Office of the Montana State Auditor, Commissioner of Securities and Insurance ("CSI") that an administrative action has been initiated against it. The Company was among more than two dozen separate parties named by the CSI in a Notice of Proposed Agency Action on May 12, 2016, that alleges potential violations of the Montana Insurance Code. The Notice, directed to the Company as well as a large pool of third-party respondents ranging from very large companies to individual insurance agents, indicated that the CSI was concerned with the possibility of unfair trade practices, potentially unlicensed insurance practices, or agents that were not properly appointed to the insurance carriers for whom products were being offered. Seventeen of the named parties, including the Company, requested a hearing before the CSI to contest the state's allegations and, in addition to reviewing its own data, the Company has requested certain materials, data, and information from the CSI in order to do so. Pending the resolution of the matter, the CSI summarily suspended the Company's license to conduct business in Montana. The state formally granted the Company's request to be heard on the issues, and a neutral Hearing Officer, experienced in the insurance industry, has been appointed to hear the matter. The Company has been cooperative with the CSI, and both parties have begun the routine exchange of information attendant to the hearing process so that the Company and the CSI can properly measure and gauge the potential of the allegations. Additional requests for information are ongoing as the Company works to understand the CSI's concerns.

While it is too early to assess whether the CSI's notice and the investigation of these organizations and individuals will have a material impact on the Company, based on the nature of the allegations and evidence provided by the CSI during the third and fourth quarters of 2016 and settlement discussions with the CSI in early 2017, the Company believes that a loss arising from the future assessment of a civil penalty in the range of $100,000 to $315,000 is probable but may vary based on the early stages of this matter. The Company and the CSI are in the process of attempting to reach a negotiated resolution and the Company will accrue funds for any settlement offers that it makes to the state. Both the Company and the CSI have expressed a willingness to explore amicable resolution options. To that end, the Company continues to regularly communicate, exchange information, and work closely with the CSI in furtherance of bringing the matter towards a mutually satisfactory resolution.

Massachusetts Regulatory Action

The Company also received notification of a civil investigative demand from the Massachusetts Attorney General's Office ("MAG") on June 16, 2016. As part of the MAG's regulatory oversight of the Massachusetts health care system and its corresponding authority to request documents from market participants, the MAG has requested certain information and documents from the Company. The information requested will be used to review the Company's sales and marketing practices, and ensure the Company is in compliance with Massachusetts laws and regulations. Additionally, the Company's materials and sales and marketing practices will be evaluated in order to ensure that they are neither deceptive nor do they constitute unfair trade practices.

The Company has provided all requested documents and materials and continues to cooperate with the MAG in order to bring the matter to an agreeable conclusion. Based on the nature of the allegations raised by the MAG and based on discussions with them, the Company believes a loss arising from the future assessment of a civil penalty is possible however, the Company has not received any formal settlement offer from the state. The Company has begun preliminary discussions with the MAG concerning resolution options to avoid the need and cost of a continuing inquiry, and the MAG has indicated it is willing to discuss such options; however, there is no guarantee that the parties will reach a mutually agreeable resolution. Any formal settlement proposal would need to be approved by the management of the MAG before it is presented to the Company and as such, the MAG will likely want to engage in additional discovery prior to doing so, and it is too early in the process to estimate a potential range of loss.

Texas Regulatory Action

In September 2016, the Texas Department of Insurance (“TDI”) notified the Company that it has instituted an enforcement action to investigate alleged violations of advertising rules and third-party administrator license requirements in connection with the sale of the Company’s products. In connection with the investigation, the TDI requested certain information, records, and explanations and the Company delivered a response and the requested information and records in November 2016. Following such date, the TDI has not taken any action, and the TDI has only communicated that it is continuing to review the matter. The Company’s position is that there have been no violations of the advertising or third-party administrator statutes in Texas, although there is no assurance that the TDI will agree with position.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

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

Our Class A common stock is listed on the NASDAQ Global Market under the symbol "HIIQ." On March 1, 2017, the last reported sale price of our Class A common stock on the NASDAQ Global Market was $17.85 per share. Our shares of Class A common stock have been publicly traded since February 8, 2013. Prior to that time there was no public market for our Class A common stock. The following table sets forth the high and low sales prices for our Class A common stock for the periods indicated as reported by the Nasdaq Global Market:

	High	Low
2016:		
First Quarter	$6.81	$5.39
Second Quarter	7.79	3.93
Third Quarter	5.96	3.84
Fourth Quarter	18.65	4.85
2015:		
First Quarter	$9.38	$6.68
Second Quarter	8.24	4.58
Third Quarter	5.30	4.00
Fourth Quarter	6.94	4.16

There is no public trading market for our Class B common stock.

HOLDERS

As of March 1, 2017, 8,914,717 shares of our Class A common stock and 6,841,667 shares of our Class B common stock were issued and outstanding. As of March 1, 2017, there were 15 Class A common stockholders of record and two Class B stockholders of record.

DIVIDEND POLICY

We have not declared dividends on our Class A common stock for the periods presented above. We currently anticipate that we will retain all available funds for use in the operation and expansion of our business, and do not anticipate paying any cash dividends in the foreseeable future. Class B common stock is not entitled to any dividend payments under our amended and restated certificate of incorporation.

UNREGISTERED SALES OF EQUITY SECURITIES

There were no unregistered sales of equity securities during the year ended December 31, 2016.

ISSUER PURCHASES OF EQUITY SECURITIES

Shares Repurchase Plan

On December 17, 2014, our Board of Directors authorized us to purchase up to 800,000 shares of our registered Class A common stock under a repurchase program which remained in place until December 31, 2016. We adopted a plan (the “Repurchase Plan”) under Rule 10b5-1 of the Exchange Act, in connection with this authorization. The Repurchase Plan allowed us to repurchase our shares of Class A common stock at times when we otherwise might be prevented from doing so under insider trading laws or self-imposed trading blackout periods.

During the year ended December 31, 2016 there were no repurchases made under the Repurchase Plan. During the year ended December 31, 2015, we repurchased 73,852 shares of our registered Class A common stock under our Repurchase Plan at an average price per share of $7.06.

Employee Awards

Pursuant to certain restricted stock award agreements, we allow the surrender of restricted shares by certain employees to satisfy statutory tax withholding obligations on vested restricted stock awards.

The following table sets forth information with respect to repurchases of our registered Class A common stock during the fiscal quarter ended December 31, 2016:

Issuer Purchases of Equity Securities

Period	Total Number of Shares Repurchased (1)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publically Announced Plans	Maximum Number of Shares That May Yet be Purchased Under the Plans
October 1, 2016 - October 31, 2016	732	$ 6.00	–	682,830
November 1, 2016 - November 30, 2016	5,287	12.57	–	682,830
December 1, 2016 - December 31, 2016	1,319	11.30	–	682,830
Total	7,338		–	

(1) Includes shares that were surrendered by employees in order to satisfy statutory tax withholding obligations in connection with the vesting of stock-based compensation awards.

ITEM 6. SELECTED FINANCIAL DATA

This item is not applicable for smaller reporting companies.

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

Management's Discussion and Analysis of Financial Condition and Results of Operations below presents the Company's operating results for each of the two years in the period ended December 31, 2016, and its financial

condition as of December 31, 2016. Except for the historical information contained herein, this report and other written and oral statements that the Company makes from time to time contain forward-looking statements, which involve substantial known and unknown risks, uncertainties and other important factors that could cause the actual results, performance or achievements of results to differ materially from any future results, performance or achievements expressed or implied by such forward-looking statements. See the section of this report entitled "Special Note Regarding Forward-Looking Statements." Among the factors that could cause actual results to differ materially are those discussed in "Risks Factors" in Item 1A of this report. In addition, the following Management's Discussion and Analysis of Financial Condition and Results of Operations should be read in connection with the information presented in the Company's consolidated financial statements and the related notes to its consolidated financial statements included in Part IV of this report.

Overview

Health Insurance Innovations, Inc. is a Delaware corporation incorporated on October 26, 2012. In this annual report, unless the context suggests otherwise, references to the "Company," "we," "us" and "our" refer (1) prior to the February 13, 2013 closing of an initial public offering ("IPO") of the Class A common stock of Health Insurance Innovations, Inc. and related transactions, to Health Plan Intermediaries, LLC ("HPI") and its consolidated subsidiaries and (2) after the IPO and related transactions, to Health Insurance Innovations, Inc. and its consolidated subsidiaries. The terms "HII", "HPIH", and "ICE" refer to the following entities on a stand-alone basis: Health Insurance Innovations, Inc., Health Plan Intermediaries Holdings, LLC, and Insurance Center for Excellence, LLC, respectively. The term "Secured" refers to (a) prior to or at the time of their July 17, 2013 acquisition by us, Sunrise Health Plans, Inc., Sunrise Group Marketing, Inc. and Secured Software Solutions, Inc., collectively, and (b) following our July 17, 2013 acquisition, the entities described in (a) and the limited liability companies into which such entities were converted shortly following such acquisition. The terms "HealthPocket" or "HP" refer to HealthPocket, Inc., our wholly owned subsidiary which was acquired by HPIH on July 14, 2014. The term "ASIA" refers to American Service Insurance Agency LLC, a wholly owned subsidiary which was acquired by HPIH on August 8, 2014. HPIH, ICE, Secured, HP and ASIA are consolidated subsidiaries of HII.

We are a developer, distributor, and cloud-based administrator of affordable individual health and family insurance plans and supplemental products. In May 2015, we launched www.AgileHealthInsurance.com, an online direct-to-consumer website, primarily using internal resources at HealthPocket.

Our Products

We are an industry leader in the sale of individual and family medical insurance plans ("IFP"), which include short-term medical ("STM") insurance plans and guaranteed-issue and underwritten hospital indemnity plans.

STM plans feature a streamlined underwriting process offering immediate coverage options. STM plans generally offer qualifying individuals insurance benefits for fixed short-term durations. Generally, our IFP premiums are substantially more affordable than the premiums of individual major medical ("IMM") plans which offer lifetime renewable coverage. Through 2016, STM plans provided up to six months, eleven months, or 364 days of health insurance coverage with a wide range of deductible and copay levels. On October 31, 2016, the Internal Revenue Service, the Employee Benefits Security Administration, and the U.S Department of Health and Human Services, collectively "HHS," published a rule limiting the duration of STM plans as further described below.

Hospital indemnity plans are insurance products which include both guaranteed-issue and underwritten plans that pay fixed cash benefits for covered procedures and services for individuals under the age of 65. These highly customizable products are on an open provider network without copayments or deductibles and do not have defined policy term lengths.

We design and structure these IFPs and supplemental products on behalf of insurance carriers and discount benefit providers. We market products to individuals through our internal distribution network and we use an external distribution network consisting of non-owned third party licensed agent call centers to market to individuals. For both our internal distribution network and our external distribution network, we administer the IFPs and supplemental products. We manage customer relations via our online member portal, which is available 24 hours a day, seven days a week. Our online enrollment process allows us to aggregate and analyze consumer data and purchasing habits to track market trends and drive product innovation.

Our scalable, proprietary, and web-based technology platform provides customers, whom we refer to as members, immediate access to the products we sell through our internal and third-party distribution channels. The health insurance products we develop are underwritten by insurance carriers, and we assume no underwriting, insurance or reimbursement risk. Members can tailor product selections to meet their personal insurance and budget needs, buy policies and print policy documents and identification cards in real-time. Our technology platform uses abbreviated online applications, some with health questionnaires, to provide an immediate accept or reject decision for products that we offer. Once an application is accepted, individuals can use our automated payment system to complete the enrollment process and obtain instant electronic access to their policy fulfillment documents, including the insurance policy, benefits schedule and identification cards. We receive credit card and Automated Clearing House ("ACH") payments directly from members at the time of sale. Our technology platform provides scalability as we add members and on a per-policy-basis, reduces the costs associated with marketing, selling, underwriting and administering policies.

Our sales of IFP and supplemental products focus on the large and under-penetrated segment of the U.S. population who are uninsured or underinsured. These respective classes include individuals not covered by employer-sponsored insurance plans, such as the self-employed, small business owners and their employees, individuals who are unable to afford the rising cost of IMM premiums, underserved "gap populations" that require insurance due to changes caused by life events: new graduates, divorcees, early retirees, military discharges, the unemployed, part-time and seasonal employees and customers seeking health insurance between the open enrollment periods created under the Patient

Protection and Affordable Care Act (“PPACA”).

As the managing general underwriter of our IFP and supplemental products, we receive all amounts due in connection with the plans we sell on behalf of the providers of the services, third-party commissions and referral fees. We refer to these total collections as premium equivalents, which typically represent a combination of premiums, fees for discount benefit plans (a non-insurance benefit product that supplements or enhances an insurance product), our enrollment fees and referral fees. From premium equivalents, we remit risk premium to carriers and amounts earned by discount benefit plan providers, who we refer to as third-party obligors, such carriers and third-party obligors being the ultimate parties responsible for providing the insurance coverage or discount benefits to the member. Our revenues consist of the balance of the premium equivalents.

We collect premium equivalents upon the initial sale of the plan and then monthly upon each subsequent periodic payment under such plan. We receive most premium equivalents through online credit card or ACH processing. As a result, we have limited accounts receivable. We remit the risk premium to the applicable carriers and the amounts earned by third-party obligors on a monthly basis based on the respective agreements.

We also provide consumers with access to health insurance information search and comparison technology through our website, HealthPocket.com. This free website allows consumers to easily and clearly compare and rank health insurance plans available for an individual, family, or small business, empowering consumers to make health plan decisions and reduce their out-of-pocket costs. In addition, the data aggregated by HealthPocket (“HP”) is used to research consumer needs and to measure product demand to help us design and manufacture high-demand insurance products. HP’s revenue is principally derived from referral fees and marketing fees, licensing fees, limited exclusivity fees, and landing page development fees.

In 2015, we launched a direct-to-consumer insurance website that allows consumers to research health insurance trends, comparison shop, and purchase IFP under the AgileHealthInsurance® brand. AgileHealthInsurance.com (“Agile”) is one of the few internet sites dedicated to helping consumers understand the benefits of Term Health Insurance. We use the term “Term Health Insurance” to refer to health insurance products of less than one year in duration, such as STM. These IFP plans are the culmination of extensive research on health insurance needs in the PPACA era, and we believe consumers will easily be able to find affordable prices for these plans on AgileHealthInsurance.com. AgileHealthInsurance.com utilizes what we believe is a best-of-class plan comparison and online enrollment tool, to accompany these new plans. The underlying technology was developed by engineers with decades of experience working on top-tier e-Commerce websites known for their ease-of-use.

On June 10, 2016, HHS proposed rule 2016-13583, that impacts STM insurance. On October 31, 2016, HHS published rule, Internal Revenue Bulletin 2016-47, substantially as proposed despite opposition from significant stakeholders during the open comment period. The rule limits STM duration to periods of less than three months but allows for re-applications with the same or different health insurance carrier. The rule also requires notification of non-compliance with the minimum essential coverage standards set forth in the Affordable Care Act. The rule goes into effect on January 1, 2017 however neither HHS nor the states will enforce the rule regarding duration or renewal of STM plans until April 1, 2017. This rule will likely have a material impact on revenues generated from the sale of STM products beginning with our 2017 fiscal year but we are not yet able to determine the impact on total revenues, if any, as we will seek to mitigate revenue losses, if any, by offering new products, by growing our already strong distribution channels and by continuing our direct-to-consumer emphasis while simultaneously increasing operating leverage.

As of December 31, 2016, we had 290,117 total plans in force, compared to 195,132 on December 31, 2015. For the year ended December 31, 2016, our premium equivalents and revenues were $311.6 million and $184.5 million, respectively, representing increases of 77.2% and 76.2% when compared to the year ended December 31, 2015. For more detail about the use of total plans in force and premium equivalents as business metrics and a reconciliation of premium equivalents to revenues, see “Key Business Metrics” below.

Key Business Metrics

In addition to traditional financial metrics, we rely upon the following key business metrics to evaluate our business performance and facilitate long-term strategic planning:

Premium equivalents. We define this metric as our total collections, including the combination of premiums, fees for discount benefit plans, enrollment fees, and third-party commissions and referral fees. All amounts not paid out as risk premium to carriers or paid out to other third-party obligors are considered to be revenues for financial reporting purposes. We have included premium equivalents in this report because it is a key measure used by our management to understand and evaluate our core operating performance and trends, to prepare and approve our annual budget and to develop short- and long-term operational plans. In particular, the inclusion of premium equivalents can provide a useful measure for period-to-period comparisons of our business. This financial measurement is considered a non-GAAP financial measure and is not recognized under generally accepted accounting principles in the United States of America (“GAAP”) and should not be used as, and is not an alternative to, revenues as a measure of our operating performance.

The following table presents a reconciliation of premium equivalents to revenues for the years ended December 31, 2016 and 2015 ($ in thousands):

	Year Ended December 31,	
	2016	2015
Premium equivalents	$311,590	$175,768
Less risk premium	121,436	67,445
Less amounts earned by third party obligors	5,638	3,619
Revenues	$184,516	$104,704

Plans in force. We consider a plan to be in force when we have issued a member his or her insurance policy or discount benefit plan and have collected the applicable premium payments and/or discount benefit fees. Our plans in force are an important indicator of our expected revenues, as we receive a monthly commission for up to six months for our six-month STM plans, up to eleven months for our eleven months plans, up to twelve months for our approximately twelve-month (i.e., up to 364 days) STM plans and can exceed twelve months for our hospital indemnity and discount benefit plans, provided that the policy or discount benefit plan is not cancelled. A member may be enrolled in more than one policy or discount benefit plan simultaneously. A plan becomes inactive upon notification to us of termination of the policy or discount benefit plan, when the member's policy or discount benefit plan expires or following non-payment of premiums or discount benefit fees when due.

The following table presents the number of policies in force by product type as of December 31, 2016 and 2015:

	As of December 31,			
	2016	2015	Change	
IFP	133,568	84,513	58.0	%
Supplemental products	156,549	110,619	41.5	%
Total	290,117	195,132	48.7	%

EBITDA. We define this metric as net income (loss) before interest expense, income taxes and depreciation and amortization. We have included EBITDA in this report because it is a key measure used by our management and board of directors to understand and evaluate our core operating performance and trends, to prepare and approve our annual budget and to develop short- and long-term operational plans. In particular, the exclusion of certain expenses in calculating EBITDA can provide a useful measure for period-to-period comparisons of our business. However, EBITDA does not represent, and should not be considered as, an alternative to net income or cash flows from operations, each as determined in accordance with GAAP. Other companies may calculate EBITDA differently than we do. EBITDA has limitations as an analytical tool, and you should not consider it in isolation or as a substitute for analysis of our results as reported under GAAP.

Adjusted EBITDA. To calculate adjusted EBITDA, we calculate EBITDA, which is then further adjusted for items that are not part of regular operating activities, including acquisition costs, restructuring costs, contract termination costs, and other non-cash items such as non-cash stock-based compensation. Adjusted EBITDA does not represent, and should not be considered as, an alternative to net income or cash flows from operations, each as determined in accordance with GAAP. We have presented adjusted EBITDA because we consider it an important supplemental measure of our performance and believe that it is frequently used by analysts, investors and other interested parties in the evaluation of companies. Other companies may calculate adjusted EBITDA differently than we do. Adjusted EBITDA has limitations as an analytical tool, and you should not consider it in isolation or as a substitute for analysis of our results as reported under GAAP.

The following table presents a reconciliation of net income to EBITDA and adjusted EBITDA for the years ended December 31, 2016 and 2015 ($ in thousands):

	Year Ended December 31,	
	2016	2015
Net income	$13,109	$1,465
Interest (income) expense	61	(22)
Depreciation and amortization	3,249	2,954
Benefit for income taxes	(4,751)	(1,922)
EBITDA	11,668	2,475
Non-cash stock-based compensation	3,792	1,364
Fair value adjustment to contingent consideration	15	(1,265)
Transaction costs	—	24
Tax receivable agreement liability adjustment	9,678	361
Severance, restructuring and other	2,609	3,623
Adjusted EBITDA	$27,762	$6,582

Adjusted net income. To calculate adjusted net income, we calculate net income then add back amortization (but not depreciation), interest, tax expense and other items that are not part of regular operating activities, including acquisition costs, restructuring costs, contract termination costs, tax receivable agreement liability adjustments, and

other non-cash items such as non-cash stock-based compensation and fair value adjustment to contingent consideration. From adjusted pre-tax net income we apply a pro forma tax expense calculated at an assumed rate of 38%. We believe that when measuring Company and executive performance against the adjusted net income measure, applying a pro forma tax rate better reflects the performance of the Company without regard to the Company's organizational tax structure. We have included adjusted net income in this report because it is a key performance measure used by our management to understand and evaluate our core operating performance and trends and because we believe it is frequently used by analysts, investors and other interested parties in their evaluation of our Company. Other companies may calculate this measure differently than we do. Adjusted net income has limitations as an analytical tool, and you should not consider it in isolation or substitution for earnings per share as reported under GAAP.

Adjusted net income per share. Adjusted net income per share is computed by dividing adjusted net income by the total number of diluted Class A and Class B shares of our common stock for each period. We have included adjusted net income per share in this report because it is a key measure used by our management to understand and evaluate our core operating performance and trends and because we believe it is frequently used by analysts, investors and other interested parties in the evaluation of companies. Other companies may calculate this measure differently than we do. Adjusted net income per share has limitations as an analytical tool, and you should not consider it in isolation or as a substitute for earnings per share as reported under GAAP.

The following table presents a reconciliation of net income to adjusted net income and adjusted net income per share for the years ended December 31, 2016 and 2015 (in thousands, except per share data):

	Year Ended December 31,	
	2016	2015
Net income	$13,109	$1,465
Interest (income) expense	61	(22)
Amortization	2,154	2,626
Provision (benefit) for income taxes	(4,751)	(1,922)
Non-cash stock-based compensation	3,792	1,364
Fair value adjustment to contingent consideration	15	(1,265)
Transaction costs	—	24
Tax receivable agreement liability adjustment	9,678	361
Severance, restructuring and other charges	2,609	3,623
Adjusted pre-tax income	26,667	6,254
Pro forma income taxes	(10,133)	(2,377)
Adjusted net income	$16,534	$3,877
Total weighted average diluted share count	14,751	14,444
Adjusted net income per share	$1.12	$0.27

Core S, G & A. We define this metric as total GAAP S, G & A adjusted for stock-based compensation, severance, restructuring and other costs, and marketing leads and advertising expense. We have included Core S, G & A in this report because it is a key measure used by our management to understand and evaluate our core operating performance and trends. Other companies may calculate this measure differently than we do. Core S, G & A has limitations as an analytical tool, and you should not consider it in isolation or as a substitute for S, G & A as reported under GAAP.

The following table presents a reconciliation of S, G & A to Core S, G & A for the years ended December 31, 2016 and 2015 ($ in thousands):

	Year Ended December 31,	
	2016	2015
Total SG&A	$51,527	$47,324
Less Stock-based compensation	3,792	1,364
Less Severance, restructuring and other charges	2,609	3,623
Less Marketing and Advertising	11,063	9,818
Core SG&A	$34,063	$32,519
% of Revenue	18.5 %	31.1 %

Results of Operations

Revenues

Our revenues primarily consist of commissions and fees earned for health insurance policies and supplemental products issued to members, enrollment fees paid by members, referral fees, fees for discount benefit plans, and administration fees paid by members as a direct result of our enrollment services, brokerage services or referral sales. Revenues reported by the Company are net of premiums remitted to insurance carriers and fees paid for discount benefit plans.

Commission rates for our products are agreed to in advance with the relevant insurance carrier and vary by carrier and policy type. Under our carrier compensation arrangements, the commission rate schedule that is in effect on the policy effective date governs the commissions over the life of the policy. In addition, we earn enrollment and administration fees on policies issued. All amounts due to insurance carriers and discount benefit vendors are reported and paid to them according to the procedures provided for in the contractual agreements between the individual carrier or vendor and us.

We continue to receive a commission payment until the plan expires or is terminated. Accordingly, a significant portion of our monthly revenues is predictable on a month-to-month basis and revenues increase in direct proportion to the growth we experience in the number of plans in force.

Revenues for the year ended December 31, 2016 were $184.5 million, an increase of $79.8 million, or 76.2%, compared to 2015. The increases were primarily due to the increase in the number of policies in force. Policies in force increased to 290,117 at December 31, 2016 from 195,132 at December 31, 2015. This increase represents a 48.7% year over year change. The increase in policies in force was due primarily to continued consumer demand for our affordable healthcare products outside of the ACA open enrollment period and the diversification and enhancement of our distribution system, including our e-Commerce division, AgileHealthInsurance.com.

Third-party Commissions

Our third-party commissions consist of fees and commissions paid to third-party distributors for selling our products to members, which we pay monthly for existing members and on a weekly basis for new members. Generally, we expect third-party commissions, as a percentage of revenue, to begin to decrease as AgileHealthInsurance.com continues to sell a larger percentage of IFPs.

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Third-party commissions for the year ended December 31, 2016 were $107.7 million, an increase of $54.0 million, or 100.6%, compared to 2015. The increases in third-party commissions were primarily due to an increase in the number of policies in force sold through non-owned distributors.

Third-party commissions represented 58.4% and 34.6% of revenues and premium equivalents, respectively, for the year ended December 31, 2016 as compared to 51.3% and 30.6% of revenues and premium equivalents for 2015. These increases were largely the result of a revenue mix shift towards non-owned call centers and away from owned call centers due to the restructuring of two of our call centers in November 2015 and increased incentives provided to several third-party distributors during the quarter. Third-party commission increases were partially off-set by lower effective commission rates for distributors with advanced commission balances.

Credit Card and ACH Fees

Our credit card and ACH fees are fees paid to our banks and processors for the collection of credit card and ACH payments. We expect credit card and ACH fees as a percentage of revenue to remain generally consistent with prior periods.

Credit card and ACH fees for the year ended December 31, 2016 were $4.0 million, an increase of $1.7 million, or 73.9%, compared to 2015. The increase in credit card and ACH fees was in line with the increase in premium equivalents.

Credit card and ACH fees represented 2.2% and 1.3% of revenues and premium equivalents, respectively, for both the years ended December 31, 2016 and 2015. These percentages are in line with our expectations.

Selling, General and Administrative Expense

Our selling, general and administrative (“S, G & A”) expenses primarily consist of personnel costs, which include salaries, bonuses, commissions, stock-based compensation, payroll taxes and benefits. S, G & A expenses also include selling and marketing expenses and travel costs associated with obtaining new distributor relationships. In addition, these expenses also include expenses for outside professional services and technology expenses, including legal, audit and financial services and the maintenance of our administrative technology platform and marketing costs for online advertising. In addition, the insurance brokerage operating expenses of Secured, ASIA and ICE are included in this category for the first eleven months of 2015 but only include ASIA through the year ended December 31, 2016 because of the restructuring that occurred in 2015. See Note 8 of the accompanying consolidated financial statements

for further information on the restructuring.

S, G & A expense for the ended December 31, 2016 was $51.5 million. This represents an increase of $4.2 million, or 8.9% for the year ended December 31, 2016 compared to 2015.

S, G & A expense represented 27.9% and 16.5% of revenues and premium equivalents, respectively, for the year ended December 31, 2016 as compared to 45.2% and 26.9% of revenues and premium equivalents for 2015.

The decrease in S, G & A expenses as a percentage of revenues for the year ended December 31, 2016 compared to the same period 2015 was attributable to our scalable technology platform and the restructuring of ICE and Secured in December of 2015 which reduced duplicative processes and consequently S, G & A expenses incurred at those entities. Such decreases in SG&A were offset by our up-front cost of acquisition at AgileHealthInsurance.com, increased stock-based compensation, and accelerated product development and implementation expenses.

Depreciation and Amortization

Depreciation and amortization expense is primarily related to the amortization of acquired intangible assets as well as depreciation of property and equipment used in our business.

Depreciation and amortization expenses for 2016 were $3.2 million, an increase of $200,000, or 6.7% compared to 2015. The increase in depreciation and amortization was primarily driven by depreciation of internal-use software.

Restructuring Expense

During the last quarter of the year ended December 31, 2015, the Company committed to and communicated a plan to restructure its operations at ICE and Secured. The Company determined certain processes and cost centers of ICE and Secured to be duplicative and recognized that efficiencies could be gained by leveraging these operations with other owned call centers. The reorganization improved profitability and scalability. As of December 31, 2015, the restructuring plan was communicated to employees and substantially complete.

There was no restructuring expense incurred for the year ended December 31, 2016. For the year ended December 31, 2015, $2.6 million is included in the consolidated statement of operations in S, G & A expense. The Company has a $3,000 remaining liability associated with the restructuring at December 31, 2016. The Company recorded a liability at December 31, 2015 of $1.3 million which is included in the consolidated balance sheet as accounts payable and accrued expenses.

In connection with the restructuring, intangible assets were reviewed for impairment at December 31, 2015 and as a result of our assessment, we recorded a loss on intangibles related to distributors of $878,000. The associated loss is included in the consolidated statement of operations as S, G & A expense. See Notes 5 and 8 of the accompanying audited financial statements for further information about our intangible assets and restructuring activities.

All liabilities associated with the restructuring approximate their fair values. All recorded liabilities are classified as current within the consolidated balance sheet.

TRA Expense

TRA expense was $9.7 million and $361,000 for the years ended December 31, 2016 and 2015, respectively. TRA expense for 2016 of $9.7 million increased significantly over prior year due primarily to the one-time, non-cash, release of the valuation allowance against the deferred tax assets. For the year ended December 31, 2015, TRA expense was $361,000. See Note 15 of the accompanying audited financial statements for further information on the TRA agreement with the holders of HPIH Series B Membership Interests.

Other Expense (Income)

Other expense of $5,000 for the year ended December 31, 2016 was comprised of miscellaneous bank fees. For the year ended December 31, 2015, other income of $178,000 included a gain of $189,000 on the deconsolidation of SIL offset by $11,000 of miscellaneous bank fees. See Note 3 of the accompanying audited financial statements for further information about SIL.

Benefit for income taxes

For 2016, we recorded a benefit for income taxes of $4.8 million, reflecting an effective tax rate of (56.8%). For 2015, we recorded a benefit for income taxes of $1.9 million, reflecting an effective tax rate of 420.4%. During 2016, the effective tax rate was significantly impacted by release of the valuation allowance provided against our deferred tax assets. The deferred tax asset was a result of obligations under the tax receivable agreement. We recorded and maintained a full valuation allowance on all of deferred tax assets of HII until December 31, 2016 when there was sufficient evidence to support the reversal of all of this allowance. When we determined that we would be able to realize our remaining deferred income tax assets in the foreseeable future, a release of all of the related valuation allowance resulted in the recognition of $8.1 million of deferred tax assets at December 31, 2016. See Note 11 of the accompanying audited financial statements for further information on income taxes and the effective tax rates.

Noncontrolling Interest

We are the sole managing member of HPIH and have 100% of the voting rights and control. As of December 31, 2016, we had a 54.0% economic interest in HPIH, and HPI and HPIS had a 46.0% economic interest in HPIH. HPI and HPIS's interest in HPIH is reflected as a noncontrolling interest on our accompanying consolidated financial statements contained elsewhere in this report.

Net income attributable to HII for 2016 included HII's share of its consolidated entities' net income and loss and a benefit for income taxes of $4.8 million. Net loss attributable to HII for 2015 included HII's share of its consolidated entities' net loss and a benefit for income taxes of $1.9 million.

On August 15, 2014, we entered into an underwriting agreement with Raymond James & Associates, Inc., as the underwriter, and HPI and HPIS, as selling stockholders (the "Selling Stockholders"). Pursuant to the underwriting agreement and an exchange agreement between the Company and Selling Stockholders (the "Exchange Agreement") under which holders of Series B Membership Interests may exchange Series B Membership Interests, together with an equal number of shares of our Class B common stock, for shares of our Class A common stock on a one-for-one basis, we issued 1,725,000 shares of Class A common stock to the Selling Stockholders. We immediately acquired the Series B Membership Interests, together with an equal number of shares of our Class B common stock from the Selling Stockholders. These Series B Membership Interests were immediately recapitalized into Series A Membership Interests in HPIH. The Selling Stockholders agreed to immediately after the exchange sell to the underwriter for resale all 1,725,000 shares of Class A common stock at a public offering price of $12.15 per share ($11.54 per share, net of underwriting discounts), for net proceeds of $19.9 million. No shares were sold by the Company in this offering. The sale by the Selling Stockholders was made pursuant to a registration statement on Form S-3. No other shares of Class A common stock have been sold pursuant to the registration statement on Form S-3. See Note 9 of the accompanying consolidated financial statements for more information on this transaction and the Exchange Agreement.

Liquidity and Capital Resources

General

As of December 31, 2016, we had $12.2 million of cash and cash equivalents.

We believe that our available cash and cash flows expected to be generated from operations will be adequate to satisfy our current and planned operations for at least the next 12 months, although we can give no assurances concerning future liquidity.

Our Indebtedness

On December 15, 2014, we entered into a three-year revolving line of credit ("RLOC") for $15.0 million with a bank. The purpose of the RLOC is to provide working capital, expand the advanced commissions program, and to help us maintain adequate liquidity. Borrowings under this facility are secured by all of our and our subsidiaries' assets, including, but not limited to, cash, accounts receivable, and property and equipment. While the Company does not expect to continue the same degree of historic expansion with the advanced commission program, the Company is evaluating alternative sources of funding to complement the program should additional growth be appropriate. As of December 31, 2016, we have no outstanding balance from draws on the RLOC and $15.0 million was available to be drawn upon.

Cash Flows

The following summary of cash flows for the periods indicated has been derived from our financial statements included elsewhere in this report.

Cash Flows from Operating Activities

Cash provided by operating activities for the year ended December 31, 2016 of $18.0 million was primarily the result of consolidated net income, before noncontrolling interests, of $13.1 million. Adjustments to reconcile net income to net cash provided by operating activities consisted of $3.2 million of depreciation and amortization of property and equipment and intangible assets and $3.8 million of stock-based compensation. The primary drivers of the net change in operating assets and liabilities were $12.5 million increase in advanced commission loans to our distributors, an increase in accounts payable, accrued expenses and other liabilities by $12.0 million, and an increase in due to member of $9.2 million. These were offset by an increase in restricted cash of $4.0 million and a decrease in accounts receivable, prepaid expenses and other current assets of $1.1 million. The increase in advanced commissions was the result of increased sales by our third-party distributors, driven by continued demand for our affordable healthcare products. The $9.2 million increase in due to member was the impact of recording the corresponding TRA liability associated with the release of the valuation allowance against our deferred tax assets.

Cash used in operating activities for the year ended December 31, 2015 of $11.3 million was primarily the result of a $19.8 million increase in advanced commission loans to our distributors. The other adjustments to reconcile net income to net cash provided by operating activities were $3.0 million of depreciation and amortization of property and equipment and intangible assets, $1.3 million of income related to fair value adjustment to the contingent consideration, and $1.4 million of stock-based compensation. The primary drivers of the net change in operating assets and liabilities were an increase in accounts payable, accrued expenses and other liabilities by $6.3 million, a

decrease in accounts receivable, prepaid expenses and other current assets of $930,000 and an increase in restricted cash of $2.0 million.

Cash Flows from Investing Activities

Our uses of cash in investing activities for the year ended December 31, 2016 of $3.1 million included cash used to fund the development of internal-use software of $3.1 million and $60,000 to purchase property and equipment.

Our primary uses of cash in investing activities for the year ended December 31, 2015 of $245,000 included cash used to fund the development of internally developed software of $1.8 million and $156,000 to purchase property and equipment, offset by the proceeds from the repayment of a loan of $1.2 million and the proceeds of matured held-to-maturity securities of $461,000.

Cash Flows from Financing Activities

During the year ended December 31, 2016, cash used by financing activities of $10.4 million was primarily attributable to proceeds received from borrowings under the RLOC of $7.5 million offset by repayments of the RLOC of $15.0 million, distributions to members for tax payments under the operating agreement of HPIH of $2.0 million, payments of $547,000 under contingent consideration obligations and payments on noncompete agreements of $192,000. See Note 17 of the accompanying consolidated financial statements for information on the operating agreement between HPIH and its members.

During the year ended December 31, 2015, cash provided by financing activities of $3.2 million was primarily attributable to proceeds received from borrowings under the RLOC of $7.5 million offset by payments of $2.6 million under contingent consideration obligations, distributions to members of $872,000 and purchases of treasury stock under our stock repurchase program of $520,000.

Revolving Line of Credit

The purpose of the RLOC is to provide working capital, expand the advanced commissions program, and to help us maintain adequate liquidity. Borrowings under this facility are secured by all of our and our subsidiaries' assets, including, but not limited to, cash, accounts receivable, and property and equipment. The stated interest rate for the RLOC is 30-day LIBOR, plus 1.95%. As of December 31, 2016, we have no outstanding balance from draws on the RLOC and $15.0 million was available to be drawn upon.

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The RLOC is subject to customary covenants and restrictions which, among other things, require us to maintain minimum working capital equal to 1.50 times the outstanding balance, and require that our maximum funded debt to tangible net worth ratio shall not exceed 1.50 at any time during the term of the RLOC. The RLOC also imposes certain nonfinancial covenants on us that would require immediate payment if we, among other things, reorganize, merge, consolidate, or otherwise change ownership or business structure without the bank's prior written consent. The RLOC is secured by a first priority security interest in substantially all of the Company's business assets.

The RLOC agreements also contain customary representations and warranties and events of default. The payment of outstanding principal under the RLOC and accrued interest thereon may be accelerated and become immediately due and payable upon default of payment or other performance obligations or failure to comply with financial or other covenants in the RLOC agreements, subject to applicable notice requirements and cure periods as provided in the RLOC agreements.

Under the terms of the RLOC, we incurred and capitalized certain costs related to acquiring the RLOC of $23,000. These costs consisted primarily of consulting and legal fees directly related to the bank loan. As of December 31, 2016 there was no balance of deferred financing costs. At December 31, 2015, the capitalized balance of the deferred financing costs of $15,000 were included in Accounts receivable, net, prepaid expenses and other current assets.

Off-Balance Sheet Arrangements

Through December 31, 2016, we had not entered into any off-balance sheet arrangements, other than the operating leases discussed in Note 15 of the accompanying consolidated financial statements.

Critical Accounting Policies and Estimates

Our significant accounting policies are outlined in Note 1 to the consolidated financial statements included in this Form 10-K. Our financial statements are prepared in accordance with GAAP. The preparation of these financial statements requires our management to make estimates, assumptions and judgments that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues and expenses during the applicable periods. We base our estimates, assumptions and judgments on historical experience and on various other factors that we believe to be reasonable under the circumstances. Different assumptions and judgments could change the estimates used in the preparation of our financial statements, which, in turn, could change the results from those reported. We evaluate our estimates, assumptions and judgments on an ongoing basis. The critical accounting estimates, assumptions and judgments that we believe have the most significant impact on our financial statements are described below. We have elected under the JOBS Act to delay adoption of new or revised accounting pronouncements applicable to public companies until

such pronouncements are made applicable to private companies. As a result of this election, our financial statements may not be comparable to companies that comply with public company effective dates.

Impairment of Goodwill

Methodology

We evaluate goodwill, which had a carrying value of $41.1 million as of December 31, 2016, for impairment at least annually, during the third quarter of each year, or whenever events or changes in circumstances indicate that the carrying amount of such assets may not be recoverable. To assess the realizability of goodwill, we have the option to first assess qualitative factors to determine whether the existence of events or circumstances leads to a determination that it is more likely than not that the fair value of a reporting unit is less than its carrying amount. We may elect to forgo this option and proceed to the annual two-step goodwill impairment test.

If we elect to perform the qualitative assessment and it indicates that a significant decline to fair value of a reporting unit is more likely than not, or if a reporting unit's fair value has historically been closer to its carrying value, or we elect to forgo this qualitative assessment, we will proceed to Step 1 testing where we calculate the fair value of a reporting unit based on discounted future probability-weighted cash flows. If Step 1 indicates that the carrying value of a reporting unit is in excess of its fair value, we will proceed to Step 2 where the fair value of the reporting unit will be allocated to assets and liabilities as it would in a business combination. Impairment occurs when the carrying amount of goodwill exceeds its estimated fair value calculated in Step 2.

Judgements and Uncertainties

A qualitative assessment will require judgments involving relevant factors, including but not limited to, changes in the general economic environment, industry and regulatory considerations, current economic performance compared to historical economic performance and other relevant company-specific events such as changes in management, key personnel or business strategy, where applicable.

While performing the reporting unit's impairment assessment we use, or have used, a combination of valuation approaches including the market approach and the income approach. The market approach uses a guideline company methodology, which is based upon a comparison of the reporting unit to similar publicly-traded companies within our industry. We derive a market value of invested capital or business enterprise value for each comparable company by multiplying the price per share of common stock of the publicly traded companies by their total common shares outstanding and adding each company's current level of debt. We calculate a business enterprise multiple based on revenue and earnings from each company, then apply those multiples to our revenue and earnings to calculate a business enterprise value. Assumptions regarding the selection of comparable companies are made based on, among other factors, capital structure, operating environment and industry. As the comparable companies were typically larger and more diversified than our business, multiples were adjusted prior to application to our revenues and earnings to reflect differences in margins, long-term growth prospects and market capitalization.

The most significant assumptions used in these analyses are those made in estimating future cash flows. In estimating future cash flows, the income approach uses a discounted debt-free cash flow analysis to measure fair value by estimating the present value of future economic benefits. To perform the discounted debt-free cash flow analysis, we develop a pro forma analysis of the reporting unit to estimate future available debt-free cash flow and discounting estimated debt-free cash flow by an estimated industry weighted average cost of capital based on the same comparable companies used in the market approach. Per FASB guidance, the weighted average cost of capital is based on inputs (e.g., capital structure, risk, etc.) from a market participant's perspective and not necessarily from the reporting unit's perspective.

Future cash flow is projected based on assumptions for our economic growth, industry expansion, future operations and the discount rate, all of which require significant judgments by management.

Effect if Actual Results Differ From Assumptions

We establish our assumptions and arrive at the estimates used in these calculations based upon our historical experience, knowledge of our industry and by incorporating third-party data, which we believe results in a reasonably accurate approximation of fair value. Nevertheless, changes in the assumptions used could have an impact on our

assessment of recoverability. We believe our projected sales are reasonable based on, among other things, available information regarding our industry. We also believe the discount rate is appropriate. The weighted average discount rate is impacted by current financial market trends and will remain dependent on such trends in the future.

If actual results differ substantially from the assumptions used in performing the impairment test, the fair value of the reporting units may be significantly lower, causing the carrying value to exceed the fair value and indicating an impairment has occurred. Absent offsetting changes in other factors, a 1% increase in the discount rate would decrease the estimated fair value of our reporting unit by approximately $5.0 million, but would not indicate impairment.

Allowance for sales returns

Methodology

The allowance for sales returns represents management's best estimate of probable returns of policies sold. This estimates is based on a rolling 12 month average of returns tracked by month of service and month of return. A blended historical and current "Open Enrollment" factor is included within the analysis to account for increased returns related to seasonal sales spikes during the open enrollment period. In an effort to identify adverse trends for sales returns and chargebacks, we perform ongoing reviews of returns.

Judgements and Uncertainties

Historical sales returns may not be an accurate representation of current sales return trends. Management monitors these returns regularly to identify trends however additional factors that impact sales returns may not be included within the analysis which could materially impact the net reported revenues.

Effect if Actual Results Differ From Assumptions

As of December 31, 2016 and 2015, our allowance accounts were $1.2 million, respectively. As a measure of sensitivity, a 1% change in the allowance calculation would have a $313,000 net effect on pre-tax earnings.

Advanced commissions allowance

Methodology

The allowance for advanced commissions represents management's best estimate of probable losses inherent in the receivable balance. These estimates are based on a multiple calculation of expected payback period relative to term length of policy sold. In an effort to identify adverse trends for advanced commissions, we perform ongoing reviews of tranche level account balances and their respective payback period. The recovery of advanced commission balances are evaluated on an account-by-account basis.

Judgements and Uncertainties

Write-offs are charged against the allowance account only after we have exhausted all collection efforts. Actual write-offs and adjustments could differ from the allowance estimates due to unanticipated changes in the business environment as well as factors and risks associated with specific distributors.

Effect if Actual Results Differ From Assumptions

As of December 31, 2016 and 2015, our allowance accounts were $454,000 and $327,000, respectively. There were no receivable balances written off in 2016 or 2015.

Currently, we do not believe that we have a significant amount of risk relative to the allowance for advanced commissions. As a measure of sensitivity, a 10% change in the allowance would have a $45,000 effect on pre-tax earnings.

Deferred tax asset and amounts due to member pursuant to the TRA agreement

Methodology

We evaluate quarterly the positive and negative evidence regarding the expected realization of net deferred tax assets. The carrying value of our net deferred tax assets is based on our assessment as to whether it is more likely than not that we will generate sufficient future taxable income to realize these deferred tax assets. We had recorded a valuation allowance against all of the deferred tax assets of HII as of December 31, 2015. We maintained a full valuation allowance on all of deferred tax assets of HII until December 31, 2016 when there was sufficient evidence to support the reversal of all of the eligible allowance.

Judgements and Uncertainties

Significant management judgment is required in determining the period in which the reversal of a valuation allowance should occur. We considered all available evidence, both positive and negative, such as historical levels of income and future forecasts of taxable income, among other items, in determining whether a full or partial release of the valuation allowance was required. In addition, our assessments required us to schedule future taxable income in accordance with the applicable tax accounting guidance to assess the appropriateness of a valuation allowance which further required the exercise of significant management judgment.

Effect if Actual Results Differ From Assumptions

When we determined that we would be able to realize our remaining deferred income tax assets in the foreseeable future, a release of all of the related eligible valuation allowance resulted in the recognition of $8.1 million of deferred tax assets at December 31, 2016 and a reduction of income tax expense of $8.1 million. The release of the valuation allowance resulted in the recognition of a $9.1 million tax receivable agreement obligation and $9.1 million in TRA expense which is in TRA expense in the consolidated statements of operations.

If actual future Company earnings are materially less than forecasted or if other underlying assumptions differ materially, the Company may not have adequate future taxable income to realize the entirety of the recorded deferred tax assets.

Stock-based compensation

Methodology

Expense for stock-based compensation is recognized based upon estimated grant date fair value and is amortized over the service period of the awards using the accelerated method. We offer awards which vest based on service conditions, performance conditions or market conditions. For grants of SARs and stock options, we apply the

Black-Scholes option-pricing model, Monte Carlo Simulation, or a lattice model, depending on the vesting conditions, in determining the fair value of share-based payments to employees.

The resulting compensation expense is recognized over the requisite service period. The requisite service period is the period during which an employee is required to provide service in exchange for an award, which often is the vesting period. Compensation expense is recognized only for those awards expected to vest. In accordance with GAAP, compensation expense is not recognized for awards with performance vesting conditions until it is deemed probable that the underlying performance events will occur. All stock-based compensation expense is classified within S, G & A expense in the condensed consolidated statements of operations.

Judgements and Uncertainties

These models incorporate various assumptions, including expected volatility and expected term. Through November of 2015, expected stock price volatilities were estimated using implied volatilities of comparable publicly-traded companies, given our limited trading history. As of December 2015, volatility is calculated using the Company's trading history. The expected term of awards granted is based on the Company's best estimate and the use of the simplified method for "plain vanilla" awards under GAAP, where applicable. Accruals of compensation cost for an award with a performance condition shall be based on the probable outcome of that performance condition. Therefore, compensation cost shall be accrued if it is probable that the performance condition will be achieved and shall not be accrued if it is not probable that the performance condition will be achieved. Such judgements can significantly impact the timing and amount of expense recognized.

Effect if Actual Results Differ From Assumptions

As a measure of sensitivity, a 1% change to our estimated forfeiture rate would have had an approximate $15,000 impact on our 2016 operating income. Our estimated forfeiture rates as of December 31, 2016 and 2015, were 7%. We do not believe there is a reasonable likelihood that there will be a material change in the future estimates or assumptions we use to determine stock-based compensation expense.

Loss contingencies

Methodology

We are involved in various lawsuits, claims, investigations, and proceedings that arise in the ordinary course of business. Certain of these matters include speculative claims for substantial or indeterminate amounts of damages. We record a liability when we believe that it is both probable that a loss has been incurred and the amount can be reasonably estimated.

Judgements and Uncertainties

Significant judgment is required to determine both probability and the estimated amount. We review these provisions at least quarterly and adjust these provisions accordingly to reflect the impact of negotiations, settlements, rulings, advice of legal counsel, and updated information.

Effect if Actual Results Differ From Assumptions

We believe that the amount or estimable range of reasonably possible loss, will not, either individually or in the aggregate, have a material adverse effect on our business or consolidated financial statements with respect to loss contingencies for legal and other contingencies as of December 31, 2016. However, the outcome of litigation is inherently uncertain. Therefore, if one or more of these legal matters were resolved against us for amounts in excess of management's expectations, our results of operations and financial condition, including in a particular reporting period, could be materially adversely affected.

Recent Accounting Pronouncements

Note 1 to the consolidated financial statements contains a summary of the Company's significant accounting policies, including a discussion of recently issued accounting pronouncements and their impact or potential future impact on the Company's financial results, if determinable, under the sub-heading "Recent Accounting Pronouncements."

Carrier Concentration

For the year ended December 31, 2016, three carriers accounted for 60% of our premium equivalents and for the year ended December 31, 2015, two carriers accounted for 70% of our premium equivalents. For the year ended December 31, 2016, HCC Life Insurance Company ("HCC") accounted for 22% of our premium equivalents, United Life Insurance Company accounted for 20%, and Companion Life Insurance Company accounted for 18%. The Company anticipates that its premium equivalents in 2017 will continue to be concentrated among a small number of carriers, although as a part of the Company's strategy of improving and increasing its product mix by seeking to add innovative new products, the Company anticipates that its carrier concentration may decrease.

On February 1, 2017, we came to mutual agreement with HCC to terminate the terms of our carrier contract with HCC. We no longer sell HCC products through any of our distribution channels. We do not expect this contract termination to have a material impact on our Company's total revenues because we have added additional world-class carriers in 2016 with market leading expertise and products. See Note 19 of the accompanying consolidated financial statements for further details.

Legal and Other Contingencies

The Company is subject to legal proceedings, claims, and liabilities that arise in the ordinary course of business. Regardless of the outcome, litigation can have an adverse impact on us because of defense and settlement costs, diversion of management resources and other factors. The Company accrues losses associated with legal claims when such losses are probable and reasonably estimable. If the Company determines that a loss is probable and cannot estimate a specific amount for that loss, but can estimate a range of loss, the best estimate within the range is accrued. If no amount within the range is a better estimate than any other, the minimum amount of the range is accrued. Estimates are adjusted as additional information becomes available or circumstances change. Legal defense costs associated with loss contingencies are expensed in the period incurred.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

This item is not applicable for smaller reporting companies.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Financial statements and exhibits filed under this item are listed in the index appearing in Item 15 of this report.

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

None.

ITEM 9A. CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures

The Company's management has evaluated, under the supervision of the Company's principal executive officer and principal financial officer, the effectiveness of its disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act.

Based on this evaluation as of December 31, 2016, the Company's principal executive officer and principal financial officer concluded that the design and operation of the Company's disclosure controls and procedures were effective as of December 31, 2016 to ensure that information required to be disclosed by us in reports that we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms, and (ii) accumulated and communicated to management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure. In designing and evaluating the disclosure controls and procedures, management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving the desired control objectives.

Management's Report on Internal Control over Financial Reporting

The Company's management, under the supervision of the Company's principal executive officer and principal financial officer, is responsible for establishing and maintaining adequate internal control over financial reporting, as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act. The Company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with GAAP. Internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company, (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with GAAP, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the Company's assets that could have a material effect on the financial statements.

The Company's management has assessed the effectiveness of our internal control over financial reporting as of December 31, 2016. In making its assessment of our internal control over financial reporting, management used Internal Control – Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 Framework). The Company's management has concluded that, as of December 31, 2016, our internal control over financial reporting was effective.

This report does not include an attestation report of the Company's independent registered public accounting firm regarding internal control over financial reporting as emerging growth companies are not required to include such report.

Changes in Internal Control over Financial Reporting

There were no changes in the Company's internal control over financial reporting during the year ended December 31, 2016 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

ITEM 9B. OTHER INFORMATION

None.

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PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

The information required by this Item is incorporated herein by reference to the information provided under the headings “Election of Directors - Nominees for Election for a One-Year Term Expiring at the 2017 Annual Meeting,” “Corporate Governance,” “Current Executive Officers” and “Section 16(a) Beneficial Ownership Reporting Compliance” in our definitive proxy statement to be filed with the Securities and Exchange Commission not later than 120 days after the fiscal year ended December 31, 2016 (the “2017 Proxy Statement”).

We have adopted a Code of Business Conduct and Ethics, which is applicable to all of our directors, employees and officers, including our principal executive officer, principal financial officer and principal accounting officer. A copy of the Code of Business Conduct and Ethics can be found at our website at www.hiiquote.com. Any amendments to or waivers from the Code of Business Conduct and Ethics will be posted on our website.

ITEM 11. EXECUTIVE COMPENSATION

The information required by this Item is incorporated herein by reference to the information provided under the headings “Corporate Governance – Board Meetings and Committees – Compensation Committee,” “Executive Compensation” and “Director Compensation” in the 2017 Proxy Statement.

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

The information required by this Item is incorporated herein by reference to the information provided under the heading “Security Ownership of Certain Beneficial Owners and Management” in the 2017 Proxy Statement.

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

The information required by this Item is incorporated herein by reference to the information provided under the heading “Certain Relationships and Related Party Transactions” in the 2017 Proxy Statement.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

The information required by this Item is incorporated herein by reference to the information provided under the heading “Fees Paid to Independent Registered Certified Public Accounting Firm in 2016 and 2015” in the 2017 Proxy Statement.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

INDEX TO FINANCIAL STATEMENTS

Health Insurance Innovations, Inc.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Board of Directors and Stockholders

Health Insurance Innovations, Inc.

We have audited the accompanying consolidated balance sheets of Health Insurance Innovations, Inc. (a Delaware corporation) and subsidiaries (the "Company") as of December 31, 2016 and 2015, and the related consolidated statements of operations, changes in stockholders' equity, and cash flows for each of the two years in the period ended December 31, 2016. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Company's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Health Insurance Innovations, Inc. and subsidiaries as of December 31, 2016 and 2015, and the results of their operations and their cash flows for each of the two years in the period ended December 31, 2016 in conformity with accounting principles generally accepted in the United States of America.

/s/ GRANT THORNTON LLP

Tampa, Florida

March 2, 2017

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HEALTH INSURANCE INNOVATIONS, INC.

Consolidated Balance Sheets

($ in thousands, except share and per share data)

	December 31,	
	2016	2015
Assets		
Current assets:		
Cash and cash equivalents	$12,214	$7,695
Restricted cash	11,938	7,906
Accounts receivable, net, prepaid expenses and other current assets	2,815	1,778
Advanced commissions, net	37,001	24,531
Income taxes receivable	—	591
Total current assets	63,968	42,501
Property and equipment, net	4,022	2,004
Goodwill	41,076	41,076
Intangible assets, net	7,907	10,061
Deferred tax asset	8,181	—
Other assets	193	142
Total assets	$125,347	$95,784
Liabilities and stockholders' equity		
Current liabilities:		
Accounts payable and accrued expenses	$29,680	$17,847
Deferred revenue	430	384
Current portion of contingent acquisition consideration	—	532
Income taxes payable	2,121	—
Due to member	3,282	342
Other current liabilities	126	203
Total current liabilities	35,639	19,308
Revolving line of credit	—	7,500
Deferred tax liability	—	358
Due to member	9,460	406
Other liabilities	170	158
Total liabilities	45,269	27,730
Commitments and contingencies		
Stockholders' equity:		
Class A common stock (par value $0.001 per share, 100,000,000 shares authorized; 8,156,249 and 7,910,085 shares issued as of December 31, 2016 and 2015, respectively; and 8,036,705 and 7,759,092 shares outstanding as of December 31, 2016 and 2015, respectively)	8	8
Class B common stock (par value $0.001 per share, 20,000,000 shares authorized; 6,841,667 shares issued and outstanding as of December 31, 2016 and 2015, respectively)	7	7
Preferred stock (par value $0.001 per share, 5,000,000 shares authorized; no shares issued and outstanding as of December 31, 2016 and 2015, respectively)	—	—

Additional paid-in capital	47,849	44,591
Treasury stock, at cost (119,544 and 150,993 shares as of December 31, 2016 and 2015, respectively)	(1,122)	(1,542)
Retained earnings (accumulated deficit)	1,420	(3,093)
Total Health Insurance Innovations, Inc. stockholders' equity	48,162	39,971
Noncontrolling interests	31,916	28,083
Total stockholders' equity	80,078	68,054
Total liabilities and stockholders' equity	$125,347	$95,784

See accompanying notes to the consolidated financial statements.

Health Insurance Innovations, Inc.

Consolidated Statements of Operations

($ in thousands, except share and per share data)

	Year Ended December 31,	
	2016	2015
Revenues (premium equivalents of $311,590 and $175,768 for the years ended December 31, 2016 and 2015, respectively)	$184,516	$104,704
Operating expenses:		
Third-party commissions	107,663	53,700
Credit card and ACH fees	3,960	2,287
Selling, general and administrative	51,527	47,324
Depreciation and amortization	3,249	2,954
Total operating expenses	166,399	106,265
Income (loss) from operations	18,117	(1,561)
Other expense (income):		
Interest expense (income)	61	(22)
Fair value adjustment to contingent acquisition consideration	15	(1,265)
TRA expense	9,678	361
Other expense (income)	5	(178)
Net income (loss) before income taxes	8,358	(457)
Benefit for income taxes	(4,751)	(1,922)
Net income	13,109	1,465
Net income attributable to noncontrolling interests	8,596	864
Net income attributable to Health Insurance Innovations, Inc.	$4,513	$601
Per share data:		
Net income per share attributable to Health Insurance Innovations, Inc.		
Basic	$0.59	$0.08
Diluted	$0.57	$0.08
Weighted average Class A common shares outstanding		
Basic	7,599,533	7,524,566
Diluted	7,909,235	7,601,789

See accompanying notes to the consolidated financial statements.

Health Insurance Innovations, Inc.

Consolidated Statements of Stockholders' Equity

($ in thousands, except share data)

	Health Insurance Innovations, Inc.									
	Class A Common Stock		Class B Common Stock			Treasury Stock				
	Shares	Amount	Shares	Amount	Additional Paid-in Capital	Shares	Amount	(Accumulated Deficit) Retained Earnings	Noncontrolling Interests	Stockholders' Equity
Balance as of January 1, 2015	7,852,941	$ 8	6,841,667	$ 7	$ 42,647	47,144	$ (347)	$ (3,694)	$ 28,091	$ 66,712
Net income	—	—	—	—	—	—	—	601	864	1,465
Repurchases of Class A common stock	(73,852)	—	—	—	—	73,852	(520)	—	—	(520)
Issuance of Class A common stock under equity compensation plans	10,000	—	—	—	—	—	—	—	—	—
Class A common stock withheld in Treasury from restricted share vesting	(17,081)	—	—	—	—	17,081	(95)	—	—	(95)
Forfeiture of restricted stock held in Treasury	(164,132)	—	—	—	2,125	164,132	(2,125)	—	—	—
Issuances of restricted shares from treasury	151,216	—	—	—	(1,545)	(151,216)	1,545	—	—	—
Stock compensation expense	—	—	—	—	1,364	—	—	—	—	1,364
Distributions	—	—	—	—	—	—	—	—	(872)	(872)
	7,759,092	$ 8	6,841,667	$ 7	$ 44,591	150,993	$ (1,542)	$ (3,093)	$ 28,083	$ 68,054

Balance as of December 31, 2015										
Net income	—	—	—	—	—	—	—	4,513	8,596	13,109
Issuance of Class A common stock under equity compensation plans	246,164	—	—	—	19	—	—	—	—	19
Class A common stock withheld in Treasury from restricted share vesting	(21,397)	—	—	—	—	21,397	(160)	—	—	(160)
Forfeiture of restricted stock held in Treasury	(43,600)	—	—	—	345	43,600	(345)	—	—	—
Issuances of restricted shares from treasury	75,749	—	—	—	(721)	(75,749)	721	—	—	—
Issuances of Class A common stock from treasury	20,697	—	—	—	(183)	(20,697)	204	—	—	21
Stock compensation expense	—	—	—	—	3,792	—	—	—	—	3,792
Contributions (distributions)	—	—	—	—	6	—	—	—	(4,763)	(4,757)
Balance as of December 31, 2016	8,036,705	$ 8	6,841,667	$ 7	$47,849	119,544	$(1,122)	$1,420	$31,916	$80,078

See accompanying notes to the consolidated financial statements.

Health Insurance Innovations, Inc.

Consolidated Statements of Cash Flows

($ in thousands)

	Year Ended December 31,	
	2016	2015
Operating activities:		
Net income	$13,109	$1,465
Adjustments to reconcile net income to net cash provided by (used in) operating activities:		
Stock-based compensation	3,792	1,364
Depreciation and amortization	3,249	2,954
Fair value adjustments to contingent acquisition consideration	15	(1,265)
Gain on deconsolidation of variable interest entity	—	(189)
Impairment of assets	—	1,013
Deferred income taxes	(8,539)	(1,942)
Changes in operating assets and liabilities:		
Increase in restricted cash	(4,032)	(1,993)
(Increase) decrease in accounts receivable, prepaid expenses and other assets	(1,088)	930
Increase in advanced commissions	(12,470)	(19,792)
Decrease (increase) in income taxes receivable	591	(579)
Increase in income taxes payable	2,121	—
Increase in accounts payable, accrued expenses and other liabilities	11,960	6,321
Increase in deferred revenue	46	320
Increase in due to member pursuant to tax receivable agreement	9,233	132
Net cash provided by (used in) operating activities	17,987	(11,261)
Investing activities:		
Capitalized internal-use software and website development costs	(3,052)	(1,783)
Proceeds from note receivable	—	1,231
Maturities of held-to-maturity investments	—	461
Purchases of property and equipment	(61)	(156)
Net cash used in investing activities	(3,113)	(247)
Financing activities:		
Proceeds from borrowings under revolving line of credit	7,500	7,500
Payments on borrowings under revolving line of credit	(15,000)	—
Payments for contingent acquisition consideration	(547)	(2,603)
Payments for noncompete obligation	(192)	(192)
Class A common stock withheld in treasury from restricted share vesting	(160)	(95)
Issuances of Class A common stock under equity compensation plans	19	—
Issuances of Class A common stock from treasury	21	—
Purchases of Cass A common stock pursuant to share repurchase plan	—	(520)
Distributions to member	(1,996)	(872)
Net cash (used) provided by financing activities	(10,355)	3,218
Net increase (decrease) in cash and cash equivalents	4,519	(8,290)

Cash and cash equivalents at beginning of period	7,695	15,985
Cash and cash equivalents at end of period	$12,214	$7,695
Supplemental disclosure of non-cash financing activities:		
Declared but unpaid distribution to member of Health Plan Intermediaries Holdings, LLC	2,761	—

See accompanying notes to the consolidated financial statements.

HEALTH INSURANCE INNOVATIONS, INC.

Notes to Consolidated Financial Statements

December 31, 2016

1. Organization, Basis of Presentation, and Summary of Significant Accounting Policies

In this annual report, unless the context suggests otherwise, references to the "Company," "we," "us" and "our" refer (1) prior to the February 13, 2013 closing of an initial public offering ("IPO") of the Class A common stock of Health Insurance Innovations, Inc. and related transactions, to Health Plan Intermediaries, LLC ("HPI") and its consolidated subsidiaries and (2) after the IPO and related transactions, to Health Insurance Innovations, Inc. and its consolidated subsidiaries. The terms "HII", "HPIH", and "ICE" refer to the stand-alone entities Health Insurance Innovations, Inc., Health Plan Intermediaries Holdings, LLC, and Insurance Center for Excellence, LLC, respectively. The term "Secured" refers to (a) prior to or at the time of their July 17, 2013 acquisition by us, Sunrise Health Plans, Inc., Sunrise Group Marketing, Inc. and Secured Software Solutions, Inc., collectively, and (b) following our July 17, 2013 acquisition, the entities described in (a) and the limited liability companies into which such entities were converted shortly following such acquisition. The term "SIL" refers to Simple Insurance Leads LLC, previously, a partially-owned venture we and a third-party formed in June 2013; we sold our interest in SIL to our joint venture partner on March 23, 2015. The terms "HealthPocket" or "HP" refer to HealthPocket, Inc., our wholly owned subsidiary which was acquired by HPIH on July 14, 2014. The term "ASIA" refers to American Service Insurance Agency LLC, a wholly owned subsidiary which was acquired by HPIH on August 8, 2014. HPIH, ICE, Secured, HP and ASIA are consolidated subsidiaries of HII. SIL was a consolidated subsidiary of HII through March 2015.

Principles of Consolidation and Basis of Presentation

The accompanying consolidated financial statements have been prepared in accordance with generally accepted accounting principles in the United States of America ("GAAP"). The consolidated financial statements include the accounts of Health Insurance Innovations, Inc., its wholly owned subsidiaries, one of which is a Variable Interest Entity ("VIE"), of which the Company is the primary beneficiary. See Note 3 for further information on the VIE. All significant intercompany balances and transactions have been eliminated in preparing the consolidated financial statements. The results of operations for business combinations are included from their respective dates of acquisition.

Noncontrolling interests are included in the consolidated balance sheets as a component of stockholders' equity that is not attributable to the equity of the Company. We report separately the amounts of consolidated net loss or income attributable to us and noncontrolling interests.

As an “emerging growth company” as defined in the Jumpstart Our Business Startups Act of 2012 (the “JOBS Act”), we benefit from certain temporary exemptions from various reporting requirements, including, but not limited to, not being required to comply with the auditor attestation requirements of Section 404 of the Sarbanes-Oxley Act and reduced disclosure obligations regarding executive compensation in our periodic reports and proxy statements. We have also elected under the JOBS Act to delay the adoption of new and revised accounting pronouncements applicable to public companies until such pronouncements are made applicable to private companies. As a result of this election, our financial statements may not be comparable to companies that comply with public company effective dates. These exemptions will apply for a period of five years following the completion of our IPO which closed on February 13, 2013. However, if we record $1 billion in total annual gross revenue before that time or if the market value of our common stock that is held by non-affiliates exceeds $700 million as of any June 30 before that time, we would cease to be an emerging growth company as of the following December 31.

Business Description and Organizational Structure of the Company

Our Business

We are a developer, distributor and cloud-based administrator of affordable individual health and family insurance plans (“IFP”) and supplemental products, which include short-term medical (“STM”) insurance plans and guaranteed-issue and underwritten hospital indemnity plans.

STM plans provide up to six months, eleven months, or 364 days of health insurance coverage with a wide range of deductible and copay levels however, beginning April 1, 2017, new limits set STM duration to periods of less than three months but allows for re-applications with the same or different health insurance carrier. STM plans generally offer qualifying individuals insurance benefits for fixed short-term durations. STM plans feature a streamlined underwriting process offering immediate coverage options. Generally, our IFP premiums are substantially more affordable than the premiums of individual major medical (“IMM”) plans which offer lifetime renewable coverage.

Included in IFP are hospital indemnity plans which are guaranteed-issue and underwritten plans that pay fixed cash benefits for covered procedures and services for individuals under the age of 65. These highly customizable products are on an open provider network without copayments or deductibles and do not have defined policy term lengths.

We also offer a variety of additional insurance and non-insurance products such as pharmacy benefit cards, dental plans, vision plans, cancer/critical illness plans, deductible and gap protection plans and life insurance policies that are frequently purchased as supplements to IFP.

We design and structure these products on behalf of insurance carriers and discount benefit providers and market them to individuals through our internal and external distribution network. We manage customer relations via our online member portal, which is available 24 hours a day, seven days a week. Our online enrollment process allows us to aggregate and analyze consumer data and purchasing habits to track market trends and drive product innovation.

Our scalable, proprietary, and web-based technology platform provides customers, whom we refer to as members, immediate access to the products we sell through our internal and third-party distribution channels. The health insurance products we develop are underwritten by insurance carriers, and we assume no underwriting, insurance or reimbursement risk. Members can tailor product selections to meet their personal insurance and budget needs, buy policies and print policy documents and identification cards in real-time. Our technology platform uses abbreviated online applications, some with health questionnaires, to provide an immediate accept or reject decision for products that we offer. Once an application is accepted, individuals can use our automated payment system to complete the enrollment process and obtain instant electronic access to their policy fulfillment documents, including the insurance policy, benefits schedule and identification cards. We receive credit card and Automated Clearing House (“ACH”) payments directly from members at the time of sale. Our technology platform provides scalability as we add members and on a per-policy-basis, reduces the costs associated with marketing, selling, underwriting and administering policies.

Our sales of IFP and supplemental products focus on the large and under-penetrated segment of the U.S. population who are uninsured or underinsured. These respective classes include individuals not covered by employer-sponsored insurance plans, such as the self-employed, small business owners and their employees, individuals who are unable to afford the rising cost of IMM premiums, underserved “gap populations” that require insurance due to changes caused by life events: new graduates, divorcees, early retirees, military discharges, the unemployed, part-time and seasonal employees and customers seeking health insurance between the open enrollment periods created under the Patient Protection and Affordable Care Act (“PPACA”).

As the managing general underwriter of our IFP and supplemental products, we receive all amounts due in connection with the plans we sell on behalf of the providers of the services, third-party commissions and referral fees. We refer to these total collections as premium equivalents, which typically represent a combination of premiums, fees for discount benefit plans (a non-insurance benefit product that supplements or enhances an insurance product), our enrollment fees and referral fees. From premium equivalents, we remit risk premium to carriers and amounts earned by discount benefit plan providers, who we refer to as third-party obligors, such carriers and third-party obligors being the ultimate parties responsible for providing the insurance coverage or discount benefits to the member. Our revenues consist of the balance of the premium equivalents.

We collect premium equivalents upon the initial sale of the plan and then monthly upon each subsequent periodic payment under such plan. We receive most premium equivalents through online credit card or ACH processing. As a result, we have limited accounts receivable. We remit the risk premium to the applicable carriers and the amounts earned by third-party obligors on a monthly basis based on the respective agreements.

We also provide consumers with access to health insurance information search and comparison technology through our website, HealthPocket.com. This free website allows consumers to easily and clearly compare and rank health insurance plans available for an individual, family, or small business, empowering consumers to make health plan decisions and reduce their out of pocket costs. In addition, the data aggregated by HealthPocket ("HP") is used to research consumer needs and to measure product demand to help us design and manufacture high-demand insurance products.

In 2015, we launched a direct-to-consumer insurance website that allows consumers to research health insurance trends, comparison shop, and purchase IFP under the AgileHealthInsurance® brand. AgileHealthInsurance.com is one of the few internet sites dedicated to helping consumers understand the benefits of Term Health Insurance. We use the term "Term Health Insurance" to refer to health insurance products of less than one year in duration, such as STM. These new plans are the culmination of extensive research on health insurance needs in the PPACA era, and we believe consumers will easily be able to find affordable prices for these plans on AgileHealthInsurance.com. AgileHealthInsurance.com utilizes plan comparison and online enrollment tool, to accompany these new plans. The underlying technology was developed by engineers with decades of experience working on top-tier e-Commerce websites known for their ease-of-use.

Our History

Our business began operations as HPI in 2008. To facilitate the IPO, HII was incorporated in the State of Delaware in October 2012. In November 2012, through a series of transactions, HPI assigned the operating assets of our business to HPIH, and HPIH assumed the operating liabilities of HPI. Since November 2012, we have operated our business through HPIH and its subsidiaries.

Our Reorganization and IPO

HII was incorporated in the State of Delaware in October 2012 to facilitate the IPO and to become a holding company owning as its principal asset membership interests in HPIH. Since November 2012, we have operated our business through HPIH and its consolidated subsidiaries. See Note 9 for more information about the IPO.

HII sold 4,666,667 shares of common stock for $14.00 per share in the IPO on February 13, 2013. Simultaneous with the offering, HII obtained a 35% membership interest, 35% economic interest and 100% of the voting interest in HPIH.

Upon completion of the offering, HII became a holding company the principal asset of which is its interest in HPIH. All of HII's business is conducted through HPIH and its subsidiaries. HII is the sole managing member of HPIH and has 100% of the voting rights and control.

HII has two classes of outstanding capital stock: Class A common stock and Class B common stock. Class A shares represent 100% of the economic rights of the holders of all classes of our common stock to share in our distributions. Class B shares do not entitle their holders to any dividends paid by, or rights upon liquidation of, HII. Shares of our Class A common stock vote together with shares of our Class B common stock as a single class, except as otherwise required by law. Each share of our Class A common stock and our Class B common stock entitles its holder to one vote. As of December 31, 2016, Mr. Kosloske, our Chief of Product Innovation, beneficially owns 46.0% of our outstanding Class A common stock and Class B common stock on a combined basis, which equals his combined economic interest in the Company.

HPIH has two series of outstanding equity: Series A Membership Interests, which may only be issued to HII, as sole managing member, and Series B Membership Interests. The Series B Membership Interests are held by HPI and Health Plan Intermediaries Sub, LLC ("HPIS"), a subsidiary of HPI, and these entities are beneficially owned by Mr. Kosloske. As of December 31, 2016, and 2015, (i) the Series A Membership Interests held by HII represent

54.0% and 53.1%, respectively, of the outstanding membership interests, 54.0% and 53.1%, respectively, of the economic interests and 100% of the voting interests in HPIH and (ii) the Series B Membership Interests held by the entities beneficially owned by Mr. Kosloske represent 46.0% and 46.9%, respectively, of the outstanding membership interests, 46.0% and 46.9%, respectively, of the economic interests and no voting interest in HPIH.

Use of Estimates

The preparation of the consolidated financial statements in conformity with accounting principles generally accepted in the United States of America ("GAAP") requires management to make estimates, judgments, and assumptions that affect the reported amounts of assets and liabilities at the date of the consolidated financial statements. These estimates also affect the reported amounts of revenue and expenses during the reporting periods. Actual results could differ materially from those estimates.

Summary of Significant Accounting Policies

Revenue Recognition

Our revenues primarily consist of commissions and fees earned for IFP and supplemental products issued to members, enrollment fees paid by members, referral fees, fees for discount benefit plans, and administration fees paid by members as a direct result of our enrollment services, brokerage services or referral sales. Revenues reported by the Company are net of risk premiums remitted to insurance carriers and fees paid for discount benefit plans. Revenues are net of an allowance for policies expected to be cancelled by members during a limited cancellation period. We establish an allowance for estimated policy cancellations through a charge to revenues. The allowance is estimated using historical data to project future experience. Such estimates and assumptions could change in the future as more information becomes known, which could impact the amounts reported. We periodically review the adequacy of the allowance and record adjustments as necessary. The net allowance for estimated policy cancellations as of December 31, 2016 and 2015 was $641,000 and $352,000, respectively.

Commission rates for our products are agreed to in advance with the relevant insurance carrier and vary by carrier and policy type. Under our carrier compensation agreements, the commission rate schedule that is in effect on the policy effective date governs the commissions over the life of the policy. Commission revenues are earned based on commission rates contracted with insurance carriers or supplemental insurance product vendors, net of an estimate for forfeited amounts payable for future policy cancellations.

In addition, we earn enrollment and administration fees on policies issued. All amounts due to insurance carriers and discount benefit vendors are reported and paid to them according to the procedures provided for in the contractual agreements between the individual carrier or vendor and us. Risk premiums are typically reported and remitted to insurance carriers on the 15th of the month following the end of the month in which they are collected.

In concluding that revenues should be reported on a net basis, we considered Financial Accounting Standards Board ("FASB") requirements and whether we have the responsibility to provide the goods or services to the customer or if we rely on a supplier to provide the goods or services to the customer. We are not the ultimate party responsible for providing the insurance coverage or discount benefits to the member and, therefore, we are not the primary obligor in the arrangement. The supplier, or insurance carrier, bears the risk for that insurance coverage. We therefore report our revenues net of amounts paid to the contracted insurance carrier companies and discount benefit vendors.

Third-Party Commissions and Advanced Commissions

We utilize a broad network of licensed third-party distributors, in addition to our internal distributors to sell the plans that we develop. We pay commissions to these distributors based on a percentage of the policy premium that varies by type of policy. We also pay fees to the distributors for discount benefit plans issued.

Advanced commissions outstanding as of December 31, 2016 and 2015 totaled $37.0 million and $24.5 million, respectively. Advanced commissions consist of amounts advanced to certain third-party distributors. We perform ongoing credit evaluations of our distributors, all of which are located in the United States. We recover the advanced commissions by withholding future commissions earned on premiums collected over the period in which policies renew. While we have not experienced any significant write offs from commission advances, we have recognized a provision for bad debt expense of $454,000 and $327,000 for the years ended December 31, 2016 and 2015, respectively. In addition, from time to time, certain of these advanced commissions arrangements include a loan agreement for the purposes of securing the advanced payments we make. Generally, these loans will be repaid by withholding payments on future commissions earned by the distributor, as described in the respective agreements. A fee for the advance commission of up to 2% of the insurance premium sold is charged to the distributors and recognized as a reduction of the related commissions expense over the period of advance. The reductions of commission expense related to this practice for the years ended December 31, 2016 and 2015 were $2.6 million and $614,000, respectively.

Cash and Cash Equivalents

We account for cash on hand and demand deposits with banks and other financial institutions as cash. Short-term, highly liquid investments with original maturities of three months or less, when purchased, are considered cash equivalents. Investments in cash equivalents include, but are not limited to, demand deposit accounts, money market accounts and certificates of deposit with original maturities of three months or less.

Restricted Cash

In our capacity as the policy administrator, we collect premiums from members and distributors and, after deducting our earned commission and fees, remit these risk premiums to our contracted insurance carriers, discount benefit vendors and distributors. Where contractually obligated, we hold the unremitted funds in a fiduciary capacity until they are disbursed, and the use of such funds is restricted. We hold these funds in bank accounts. These unremitted amounts are reported as restricted cash in the accompanying consolidated balance sheets with the related liabilities reported in accounts payable and accrued expenses. The Company previously referred to such restricted cash as cash held on behalf of others at December 31, 2015. Restricted cash at December 31, 2016 and 2015 was $11.9 million and $7.9 million, respectively.

Accounts Receivable

Accounts receivable represent amounts due to us for premiums collected by a third-party and are generally considered delinquent 15 days after the due date. The underlying insurance contracts are cancelled retroactively if the payment remains delinquent. We have not experienced any material credit losses from accounts receivable and have not recognized a significant provision for uncollectible accounts receivable.

Property and Equipment

Property and equipment is recorded at cost, less accumulated depreciation, in the accompanying consolidated balance sheets. Depreciation expense for property and equipment is computed using the straight-line method over the following estimated useful lives:

Website development and internal-use software (1)	3 – 5 years
Computer equipment	5 years
Furniture and fixtures	7 years
Leasehold improvements	Shorter of the lease term or estimated useful life

(1) Included in property and equipment, net are certain website development and internally developed software costs. These costs incurred in the development of websites and internal-use software are either expensed as incurred or capitalized depending on the nature of the cost and the stage of development of the project under which a website or internal-use software are developed. The capitalization policies for website development and internal-use software vary as described below.

Website development

Generally, the costs incurred during the planning stage are expensed as incurred; costs incurred for activities during the website application and infrastructure development stage are capitalized; costs incurred during the graphics development stage are capitalized if such costs are for the creation of initial graphics for the website; subsequent updates to the initial graphics are expensed as incurred, unless they provide additional functionality; costs incurred during the content development stage are expensed as incurred unless they are for the integration of a database with the website, which are capitalized; and the costs incurred during the operating stage are expensed as incurred.

Upon reaching the operating phase of the website application and infrastructure phase, the capitalized costs are amortized over the estimated useful life of the asset, which we generally expect to be five years.

During the year ended December 31, 2015, we capitalized $895,000 of costs incurred, consisting primarily of direct labor, in the development of a website for which the software underlying the website will not be marketed externally. The operating phase of the development of this website commenced on July 1, 2015. No additional costs have since been capitalized. As of December 31, 2016 and 2015, $179,000 and $90,000, respectively, of amortization has been recorded related to the capitalized website development costs.

Internal-use software

Generally, the costs incurred during the preliminary project stage are expensed as incurred; costs incurred for activities during the application development stage are capitalized; and costs incurred during the post-implementation/operation stage are expensed as incurred.

Upon reaching the post-implementation/operation stage of the development of internal-use software, the capitalized costs are amortized over the estimated useful life of the asset, which we generally expect to be three years.

As of December 31, 2016 and 2015, we capitalized $3.1 million and $889,000, respectively, of costs incurred, consisting primarily of direct labor, in the application development stage of the internal-use software. Substantially all of the costs incurred during the period were part of the application development phase. As of December 31, 2016 and 2015, $774,000 and $45,000, respectively, of amortization has been recorded for projects in the post-implementation/operation phase of development.

The Company’s management periodically reviews long-lived assets for impairment whenever events or changes in business circumstances indicate that the carrying value of the assets may not be recoverable. No impairment losses were recognized for the periods presented.

Goodwill and Other Intangible Assets

Goodwill

As a result of our various acquisitions, we have recorded goodwill which represents the excess of the consideration paid over the fair value of the identifiable net assets acquired in a transaction accounted for as a business combination. An impairment test is performed by us at least annually as of October 1st of each year, or whenever events or circumstances indicate a potential for impairment.

Under FASB guidance, we have the option of performing a qualitative assessment to determine whether based on the facts and circumstances it is more likely than not that the fair value of the reporting unit exceeds the carrying value of its net assets. A qualitative assessment requires judgments involving relevant factors, including but not limited to, changes in the general economic environment, industry and regulatory considerations, current economic performance compared to historical economic performance and other relevant company-specific events such as changes in management, key personnel or business strategy, where applicable. If we elect to bypass the qualitative assessment, or if we determine, based upon our assessment of those qualitative factors that it is more likely than not that the fair value of the unit is less than its carrying value, a quantitative assessment for impairment is required. The quantitative assessment for evaluating the potential impairment of goodwill involves a two-step assessment process which requires significant estimates and judgments by us to be used during the analysis. In step one we determine if there is an indication of goodwill impairment by determining the fair value of the reporting unit’s net assets and comparing that value to the reporting unit’s carrying value including the goodwill. If the carrying value of the net assets exceed the fair value, then the second step of the impairment assessment is required. The step two assessment determines if an impairment exists, and if so, the magnitude of the impairment by comparing the estimated fair value of the reporting unit’s goodwill with the carrying amount of that goodwill. The excess of the carrying value over the estimated fair value of the goodwill determines the amount of impairment which would then be recorded as a loss on our statement of operations in the year the impairment occurred. See Note 14 for further information on our change in reporting units that occurred in the first quarter of 2015.

While performing an impairment assessment we use a combination of valuation approaches including the market approach and the income approach.

The market approach uses a guideline company methodology, which is based upon a comparison of the reporting unit to similar publicly-traded companies within our industry. We derive a market value of invested capital or business enterprise value for each comparable company by multiplying the price per share of common stock of the publicly traded companies by their total common shares outstanding and adding each company’s current level of debt. We calculate a business enterprise multiple based on revenue and earnings from each company, then apply those multiples to our revenue and earnings to calculate a business enterprise value. Assumptions regarding the selection of

comparable companies are made based on, among other factors, capital structure, operating environment and industry. As the comparable companies were typically larger and more diversified than our business, multiples were adjusted prior to application to our revenues and earnings to reflect differences in margins, long-term growth prospects and market capitalization.

The income approach uses a discounted debt-free cash flow analysis to measure fair value by estimating the present value of future economic benefits. To perform the discounted debt-free cash flow analysis, we develop a pro forma analysis of the reporting unit to estimate future available debt-free cash flow and discounting estimated debt-free cash flow by an estimated industry weighted average cost of capital based on the same comparable companies used in the market approach. Per FASB guidance, the weighted average cost of capital is based on inputs (e.g., capital structure, risk, etc.) from a market participant's perspective and not necessarily from the reporting unit's perspective. Future cash flow is projected based on assumptions for our economic growth, industry expansion, future operations and the discount rate, all of which require significant judgments by management.

We establish our assumptions and arrive at the estimates used in these calculations based upon our historical experience, knowledge of our industry and by incorporating third-party data, which we believe results in a reasonably accurate approximation of fair value. Nevertheless, changes in the assumptions used could have an impact on our assessment of recoverability. We believe our projected sales are reasonable based on, among other things, available information regarding our industry. We also believe the discount rate is appropriate. The weighted average discount rate is impacted by current financial market trends and will remain dependent on such trends in the future.

After computing a separate business enterprise value under the above approaches, we apply a weighting to them to derive the business enterprise value of the reporting unit. The weightings are evaluated each time a goodwill impairment assessment is performed and give consideration to the relative reliability of each approach at that time. The estimated fair value is then compared to the reporting unit's carrying value.

During the second quarter of 2016, the Department of Health and Human Services issued a proposal to limit the duration of STM to a period of no longer than three months compared to the current period of up to one year. The proposed rule led to a decline in stock price which was deemed to be a triggering event for a goodwill impairment analysis and accordingly the Company performed step one of the two step impairment test under GAAP. Upon completion of the step one analysis as of June 30, 2016, we determined that the fair value of the reporting unit exceeded its carrying value. As such, a step two analysis was not required. The Company also performed its annual impairment as of October 1, 2016 and upon completion of the analysis in step one we determined that the fair value of the reporting unit exceeded its carrying value. As such, a step two analysis was not required.

Our goodwill balance arose from our previous acquisitions. See Note 2 for further information on the acquisitions. See Note 5 for further discussion of our goodwill.

Other Intangible Assets

Our other intangible assets arose primarily from acquisitions. Finite-lived intangible assets are amortized over their useful lives from two to fifteen years. See Note 5 for further discussion of our intangible assets.

Intangible assets are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset or asset group may not be recoverable. Recoverability of the asset or asset group is measured by comparison of its carrying amount to undiscounted future net cash flows the asset is expected to generate. If the carrying amount of an asset or asset group is not recoverable, we recognize an impairment loss based on the excess of the carrying amount of the long-lived asset or asset group over its respective fair value which is generally determined as the present value of estimated future cash flows or as the appraised value. No impairments on intangible assets were recorded during the year ended December 31, 2016. Related to our restructuring, the Company recognized an impairment of certain intangible assets in the amount of $878,000 for the year ended December 31, 2015. See Notes 5 and 8 for further discussion on the impairment and restructuring activities.

Advertising and Marketing Costs

Advertising and marketing costs are expensed as incurred. Advertising and marketing expenses for the years ended December 31, 2016 and 2015 were $11.1 million and $9.8 million respectively and are classified as selling, general and administrative expense (“S, G & A”).

Accounting for Stock-based Compensation

Expense for stock-based compensation is recognized based upon estimated grant date fair value and is amortized over the requisite service period of the awards using the accelerated method. We offer awards which vest based on service conditions, performance conditions, or market conditions. For grants of SARs and stock options, we apply the Black-Scholes option-pricing model, a Monte Carlo Simulation, or a lattice model, depending on the vesting conditions, in determining the fair value of share-based payments to employees. These models incorporate various assumptions, including expected volatility and expected term. Through November of 2015, expected stock price

volatilities were estimated using implied volatilities of comparable publicly-traded companies, given our limited trading history. Since December 2015, volatility is calculated using the Company's trading history. The expected term of awards granted is based on the Company's best estimate and the use of the simplified method for "plain vanilla" awards under GAAP, where applicable.

The resulting compensation expense is recognized over the requisite service period. The requisite service period is the period during which an employee is required to provide service in exchange for an award, which often is the vesting period. Compensation expense is recognized only for those awards expected to vest. All stock-based compensation expense is classified within S, G & A expense in the consolidated statements of operations. We do not believe there is a reasonable likelihood there will be a material change in the future estimates or assumptions we use to determine stock-based compensation expense. See Note 10 for further discussion of stock-based compensation.

Accounting for Income Taxes

HPIH is taxed as a partnership for federal income tax purposes; as a result, it is not subject to entity-level federal or state income taxation but its members are liable for taxes with respect to their allocable shares of each company's respective net taxable income.

We are subject to U.S. corporate federal, state and local income taxes that are attributable to HII as reflected in our consolidated financial statements. We use the liability method of accounting for income taxes. Significant management judgment is required in determining the provision for income taxes and, in particular, any valuation allowance that is recorded or released against our deferred tax assets.

We evaluate quarterly the positive and negative evidence regarding the realization of net deferred tax assets. The carrying value of our net deferred tax assets is based on our belief that it is more likely than not that we will generate sufficient future taxable income to realize these deferred tax assets.

We account for uncertainty in income taxes using a two-step process. The first step is to evaluate the tax position for recognition by determining if the weight of available evidence indicates that it is more likely than not that the position will be sustained upon audit, including resolution of related appeals or litigation processes, if any. The second step requires us to estimate and measure the tax benefit as the largest amount that is more than 50% likely to be realized upon ultimate settlement. Such amounts are subjective, as a determination must be made on the probability of various possible outcomes. We reevaluate uncertain tax positions on a quarterly basis. This evaluation is based on factors including, but not limited to, changes in facts or circumstances, changes in tax law, effectively settled issues under audit, and new audit activity. Such a change in recognition and measurement could result in recognition of a tax benefit or an additional tax provision. The Company accounts for interest and penalties associated with uncertain tax positions as a component of tax expense, and none were included in the Company's financial statements as there are not uncertain tax positions outstanding as of December 31, 2016 and 2015, respectively. See Note 11 for further discussion of income taxes.

Basic and Diluted Earnings per Share

Basic earnings per share is determined by dividing the net earnings attributable to Class A common stockholders by the weighted average number of Class A common shares and participating securities outstanding during the period. Participating securities are included in the basic earnings per share calculation when dilutive. Diluted earnings per share is determined by dividing the net income attributable to common stockholders by the weighted average number of common shares and potential common shares outstanding during the period. Potential common shares are included in the diluted earnings per share calculation when dilutive. Potential common shares consisting of common stock issuable upon exercise of outstanding SARs and options are computed using the treasury stock method. See Note 12 for further discussion of earnings per share.

The Company has two classes of common stock: Class A common stock and Class B common stock. Holders of each of Class A common stock and Class B common stock are entitled to one vote per share on all matters to be voted upon by the shareholders, and holders of each class will vote together as a single class on matters presented to our stockholders for their vote or approval, except as otherwise required by applicable law. For more information on our classes of stock, see Note 9.

Fair Value Measurements

We measure and report financial assets and liabilities at fair value on a recurring basis. Fair value is defined as the exchange price that would be received for an asset or paid to transfer a liability (referred to as an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. Valuation techniques used to measure fair value must maximize the use of observable inputs and minimize the use of unobservable inputs. The fair value of our financial assets and liabilities is determined by using three levels of input, which are defined as follows:

Level 1: Quoted prices in active markets for identical assets or liabilities.

Level 2: Quoted prices in active markets for similar assets or liabilities, quoted prices for identical or similar assets or liabilities in markets that are not active, or inputs other than quoted prices that are observable for the asset or liability.

Level 3: Unobservable inputs for the asset or liability.

The categorization of a financial instrument within the valuation hierarchy is based upon the lowest level of input that is significant to the fair value measurement.

We utilize the market approach to measure the fair value of our financial assets. As subjectivity exists with respect to many of the valuation techniques, the fair value estimates we have disclosed may not equal prices that we may ultimately realize if the assets are sold or the liabilities are settled with third parties. See Note 13 for a description of our valuation methods.

Recent Accounting Pronouncements

In the following summary of recent accounting pronouncements, all references to effective dates of FASB guidance relate to nonpublic entities. As noted above, we have elected to delay the adoption of new and revised accounting standards until those standards would otherwise apply to nonpublic companies under provisions of the JOBS Act.

Recently adopted accounting pronouncements

In November 2015, the FASB issued an amendment to its accounting guidance related to the classification of deferred tax assets and liabilities. To simplify the presentation of deferred income taxes, the amendments in this update require that deferred tax liabilities and assets be classified as noncurrent in a classified statement of financial position. For public business entities, the amendments in this update are effective for financial statements issued for annual periods beginning after December 15, 2016, and interim periods within those annual periods. For all other entities, this update is effective for fiscal years beginning after December 15, 2017. Early adoption is permitted and companies may elect retrospective or prospective application. This ASU was introduced as part of the FASB’s simplification initiative and we have elected to early adopt this guidance as of December 31, 2015. Adoption of this update did not materially impact the Company’s consolidated financial statements.

Recently issued accounting pronouncements

In January 2017, the FASB issued a new accounting standard update on simplifying the accounting for goodwill impairment. The new guidance eliminates the requirement to calculate the implied fair value of goodwill (i.e., Step 2 of the goodwill impairment test) to measure a goodwill impairment charge. Instead, entities will record an impairment charge based on the excess of a reporting unit's carrying amount over its fair value. This guidance will be effective for interim or annual goodwill impairment tests in fiscal years beginning after December 15, 2019 and will be applied prospectively. Early adoption is permitted for any impairment tests performed after January 1, 2017. We are still evaluating the effect that this guidance will have on our consolidated financial statements and related disclosures.

In November 2016, the FASB issued an update which requires companies to include amounts generally described as restricted cash and restricted cash equivalents in cash and cash equivalents when reconciling beginning-of-period and end-of-period total amounts shown on the statement of cash flows. The amendments in this update are effective for public business entities for fiscal years beginning after December 15, 2017, and interim periods within those fiscal years. For all other entities, the amendments are effective for fiscal years beginning after December 15, 2018, and interim periods within fiscal years beginning after December 15, 2019. Early adoption is permitted, including adoption in an interim period. If an entity early adopts the amendments in an interim period, any adjustments should be reflected as of the beginning of the fiscal year that includes that interim period. We are still evaluating the effect that this guidance will have on our consolidated financial statements and related disclosures.

In August 2016, the FASB issued an update to the presentation of certain cash receipts and cash payments as presented and classified in the statement of cash flows. The update provides amendments to the codification for eight specific cash flow issues such as the classification of debt prepayment or debt extinguishment costs to the classification of the proceeds from the settlement of insurance claims. The amendments in this update are effective for public business entities for fiscal years beginning after December 15, 2017, and interim periods within those fiscal years. For all other entities, the amendments are effective for fiscal years beginning after December 15, 2018, and interim periods within fiscal years beginning after December 15, 2019. Early adoption is permitted, including adoption in an interim period. We will adopt this guidance in reporting periods beginning after December 15, 2018. We are currently evaluating the impact of this guidance on our consolidated financial statements.

In March 2016, the FASB issued an amendment to its accounting guidance for stock compensation as part of the FASB's simplification initiative. The amendments affect all entities that issue share-based payment awards to their employees. The areas for simplification involve several aspects of the accounting for share-based payment transactions, including the income tax consequences, classification of awards as either equity or liabilities, and classification on the statement of cash flows. Some of the areas for simplification apply only to nonpublic entities. For public business entities, the amendments in this update are effective for annual periods beginning after December 15, 2016, and interim periods within those annual periods. For all other entities, the amendments are effective for annual periods beginning after December 15, 2017, and interim periods within annual periods beginning after December 15, 2018. Early adoption is permitted for any entity in any interim or annual period. We will adopt this guidance in reporting periods beginning after December 15, 2017. We are currently evaluating the impact of this guidance on our

consolidated financial statements.

In February 2016, the FASB issued an amendment to its accounting guidance for leases to increase transparency and comparability by requiring organizations to recognize lease assets and lease liabilities on the balance sheet and increasing disclosures about key leasing arrangements. The amendment updates the critical determinant from capital versus operating to whether a contract is or contains a lease because lessees are required to recognize lease assets and lease liabilities for all leases – financing and operating – other than short term. The amendments in this update are effective for public business entities for fiscal years beginning after December 15, 2018, and interim periods within those fiscal years. Early adoption is permitted. We will adopt this guidance in reporting periods beginning after December 15, 2018. While a full analysis has not been completed at this time, the Company does not believe that the impact of adopting this pronouncement will be material to our consolidated financial statements. See Note 15 for further information on our leases.

In May 2014, the FASB issued an amendment to its accounting guidance related to revenue recognition. The amendment clarifies the principles for recognizing revenue. The guidance is based on the principle that revenue is recognized to depict the transfer of goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The guidance also requires additional disclosure about the nature, amount, timing and uncertainty of revenue and cash flows arising from customer contracts, including significant judgments and changes in the judgments and assets recognized from costs incurred to obtain or fulfill a contract. For a public entity, the amendments in this update and the related deferral guidance are effective for annual reporting periods beginning after December 15, 2017, including interim periods within that reporting period. For all other entities, the amendments in this update are effective for annual reporting periods beginning after December 15, 2018, and interim periods within annual periods beginning after December 15, 2018. Early adoption is not permitted. We will adopt this guidance in reporting periods beginning after December 15, 2018. The new standard is required to be applied retrospectively to each prior reporting period presented or retrospectively with the cumulative effect of initially applying it recognized at the date of initial application. We have not yet selected a transition method nor have we determined the impact of the new standard on our consolidated financial statements. We have not determined the effect of the update on our internal control over financial reporting or other changes in business practices and processes but will do so in the design and implementation phase which is to occur throughout the next year.

2. Business Acquisitions

Acquisition of HP

On July 14, 2014, we entered into an agreement to acquire (the "Merger Agreement") HP from Mr. Bruce Telkamp ("Telkamp"), Dr. Sheldon Wang ("Wang") and minority equity holders of HP. The closing of the acquisition occurred on July 14, 2014 simultaneous with the signing of the Merger Agreement.

Pursuant to the Merger Agreement, at the closing, we paid consideration consisting of approximately $21.9 million in cash and 900,900 shares of Class A common stock, $0.001 par value per share, with such shares of the Class A common stock having a fair value of $6.7 million as of the acquisition date. A portion of the merger consideration consisting of $3.2 million in cash was deposited with an escrow agent to fund payment obligations with respect to post-closing working capital adjustments, post-closing indemnification obligations of HP's former equity holders, and fees and expenses of the representative of HP's former equity holders.

All vested options and warrants to acquire shares of HP's capital stock were terminated in connection with the acquisition, and the holders thereof received in cash a portion of the aggregate consideration upon the terms and subject to the conditions set forth in the Merger Agreement. All unvested options to acquire shares of HP's capital stock were converted into options to acquire shares of our Class A common stock ("Replacement Options") upon the terms and subject to the conditions set forth in the Merger Agreement. The total number of Replacement Options was 84,909. Pursuant to the Merger Agreement, this amount offset the total number of shares included in the consideration. The Replacement Options are included as a component of stock-based compensation on the accompanying consolidated statements of operations. See Note 9 for information on the Replacement Options. As of December 31, 2015, the net amount of shares of Class A common stock issued as a result of the acquisition was 815,991.

Under the terms of the Merger Agreements, the former equity holders of HP may have elected to receive cash or shares of our Class A common stock. Telkamp and Wang have agreed to accept cash and common stock, including 50% each of any of the shares that were issued as part of the aggregate consideration that are not elected to be received as consideration by other former HP equity holders.

The goodwill allocated to the purchase price was calculated as the fair value of the consideration less the assets acquired and liabilities assumed. This value is primarily related to the expected results of future operations of HP and the operational and technological synergies we expect to realize as a result of the acquisition.

Effective July 14, 2014, our Board of Directors appointed Mr. Telkamp as our Chief Operating Officer and we entered into an employment agreement with Mr. Telkamp where he also agreed to continue to serve as HP's Chief Executive Officer. Telkamp's employment agreement provides for, among other things, a noncompetition covenant beginning on July 14, 2014 and ending on the last day of any salary continuation period (as defined in Telkamp's employment agreement). In addition, the Merger Agreement provides for, among other things, a noncompetition covenant applicable to Telkamp beginning on July 14, 2014 and ending on July 14, 2017. On May 4, 2015, Telkamp's employment agreement was amended, and he became the Chief Executive Officer of our Consumer Division. Telkamp will continue to serve as Chief Executive Officer of HP. In addition, effective July 14, 2014, HII's Board of Directors appointed Wang as our Chief Technology Officer and we entered into an employment agreement with Wang in which he also agreed to continue to serve as HP's President. Wang's employment agreement provides for, among other things, a noncompetition covenant beginning on July 14, 2014 and ending on the last day of any salary continuation period (as defined in Wang's employment agreement). In addition, the Merger Agreement provides for, among other things, a noncompetition covenant applicable to Wang beginning on July 14, 2014 and ending on July 14, 2017.

Acquisition of ASIA

On August 8, 2014, we entered into an agreement (the "Purchase Agreement") to acquire all of the issued and outstanding membership interests of ASIA, a Texas insurance brokerage, from Mr. Landon Jordan ("Jordan") for an initial cash payment of $1.8 million, comprised of a prior deposit of $325,000 and a closing payment of $1.5 million, and $2.2 million in contingent consideration, as described below. The closing of the acquisition occurred on August 8, 2014 simultaneous with the signing of the Purchase Agreement.

Pursuant to the ASIA Purchase Agreement, Jordan was eligible to receive total contingent consideration of $2.2 million, payable in cash. This amount was payable in two cash payments of $1.2 million and $1.0 million, respectively, if ASIA attained certain amounts of adjusted EBITDA, as defined in the ASIA Purchase Agreement, during each of the periods from September 1, 2014 through August 31, 2015, and September 1, 2015 through August 31, 2016.

At December 31, 2014, the fair value of the contingent consideration for both tranches was $1.4 million. During the year ended December 31, 2015, ASIA did not meet the required EBITDA for the first earnout period and it was determined that the likelihood of meeting the second earnout period was not probable. As a result, in 2015, the Company wrote down the remaining contingent liability of $1.4 million with the corresponding reversal recorded as a fair value adjustment of contingent consideration on the consolidated statement of operations. Simultaneously, the Company terminated its employment agreement with Jordan. In connection with Jordan's termination, the Company recorded $825,000 in severance and settlement related charges which are recorded in the S, G & A expenses line item on the consolidated statement of operations. See Note 8 for details of the restructuring.

As of December 31, 2016, the amount of goodwill acquired that we expect to be deductible for income tax purposes is $1.4 million.

Acquisition of Secured

On July 17, 2013, we consummated a Stock Purchase Agreement (the "Purchase Agreement") with Joseph Safina, Howard Knaster and Jorge Saavedra (collectively, the "Sellers"), pursuant to which we acquired from the Sellers all of the outstanding equity of each of the Secured entities, which consisted of Sunrise Health Plans, Inc., a licensed insurance broker, Sunrise Group Marketing, Inc., a call center and sales lead management company, and Secured Software Solutions, Inc., an intellectual property holding company, each of which was converted to a limited liability company shortly after closing, for a cash payment of $10.0 million plus approximately $6.6 million of contingent consideration which included contingent stock awards and a note payable. The funding of the $10.0 million cash portion of the purchase price was provided primarily from net proceeds from the IPO.

Modifications of Secured Contingent Consideration

In November 2013, HPIH and the Sellers reached an agreement to modify the contingent consideration, including the thresholds to earn such contingent consideration, and to terminate the contingent stock awards and note payable. Instead, the contingent consideration was payable in cash only and included a one-time payment of $1.0 million, which was paid in November 2013, and fixed and variable components of $250,000 (up to a maximum of $3.0 million) and $200,000 (up to a maximum of $2.4 million), respectively. In addition, one of the principals severed his employment with Sunrise Health Plans, Inc. and entered into a consulting arrangement with the Company.

In May 2015, we entered into an agreement to modify the remaining contingent consideration. Pursuant to this modification, the remaining maximum payout under the existing contingent consideration terms allocable to Safina was paid in a lump-sum of $973,000 on May 7, 2015. The remaining payouts allocable to Knaster and Saavedra, which began on May 29, 2015, continued to be paid ratably and monthly through June 30, 2016.

As of December 31, 2016, the Company had no remaining balance of contingent consideration reported on the consolidated balance sheet. The fair value of contingent consideration as of December 31, 2015 was $532,000 and is included in contingent acquisition consideration on the accompanying consolidated balance sheet. During the years ended December 31, 2016 and 2015 we recorded $15,000 and $128,000, respectively, in adjustments to fair value of the contingent consideration, which is included in fair value adjustment of contingent consideration on the accompanying consolidated statement of operation.

As of December 31, 2016, we had made total payments of $6.4 million under the contingent consideration agreement, and there is no remaining payments under the agreement. As of December 31, 2015, we had made total payments of $5.9 million under the contingent consideration agreement, and the maximum remaining payments under the agreement total $547,000.

As of December 31, 2016, the amount of goodwill acquired that we expect to be deductible for income tax purposes is $10.5 million.

As of December 31, 2015, the Company committed to and communicated a plan to restructure its operations at Secured. See Note 8 for additional information.

3. Variable Interest Entities

As of December 31, 2015, we are the primary beneficiary of one entity that constitutes a VIE pursuant to FASB guidance.

HPIH

As of December 31, 2016, we are the primary beneficiary of one entity, HPIH, that constitutes a VIE pursuant to FASB guidance. HPIH is a VIE as the voting rights of the investors are not proportional to their obligations to absorb the expected losses of HPIH. We hold 100% of the voting power in HPIH, but 54.0% of the total membership and economic interest, and the other members of HPIH hold no voting rights in HPIH. Further, substantially all of the activities of HPIH are conducted on behalf of a membership with disproportionately few voting rights. We have concluded that we are the primary beneficiary of HPIH, and, therefore, should consolidate HPIH since we have power over and receive the benefits of HPIH. We have the power to direct the activities of HPIH that most significantly impact its economic performance. Our equity interest in HPIH obligates us to absorb losses of HPIH and gives us the right to receive benefits from HPIH related to the day-to-day operations of the entity, both of which could potentially be significant to HPIH. As such, our maximum exposure to loss as a result of our involvement in this VIE is the net income or loss allocated to us based on our interest.

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On August 15, 2014, the non-HII members of HPIH exchanged 1,725,000 Class B Membership Units of HPIH (together with an equal number of shares of HII Class B common stock) in exchange for an equal number of Class A common stock pursuant to an Exchange Agreement (the "Exchange Agreement"). See Note 9 for further information on the Exchange Agreement and this transaction. This transaction resulted in HII obtaining greater than 50% of the membership and economic interest of HPIH. As of December 31, 2016 and 2015, HII holds 100% of the voting power, respectively, and 54.0% and 53.1% of the membership and economic interest in HPIH, respectively.

SIL

On October 7, 2013, HPIH entered into a Limited Liability Company Operating Agreement (the "SIL LLC Agreement") with Health Benefits One, LLC ("HBO") in connection with the formation of SIL, a venture that was intended to procure sales leads for us and our distributors. Per the SIL LLC Agreement, HPIH could, without the consent of HBO, cause SIL to take any significant actions affecting SIL's day-to-day operations, including the sale or disposition of SIL assets and entrance into voluntary liquidation or receivership of SIL. As such, we determined that we had the power to control the day-to-day activities of SIL and concluded that we were the primary beneficiary of SIL, and therefore, we consolidated 100% of SIL as we had power over and received the benefits of SIL.

On March 23, 2015, we entered into a Unit Purchase Agreement (the "Unit Purchase Agreement") to sell our interests in SIL to HBO in exchange for a note receivable from HBO with a face amount of $246,000 and the right to receive certain contingent consideration. The parties agreed that this note will be payable with credits against sales commissions due to HBO, and any such commissions earned during the term of the note will be applied against the outstanding balance payable to us under the note. As of December 31, 2016 the note was repaid in full and no outstanding balance is owed the Company. The note is included in advanced commissions in the accompanying consolidated balance sheet as of December 31, 2015. In addition, we may receive contingent consideration equal to 10.0% of SIL's earnings before interest, taxes, depreciation and amortization, as defined in the Unit Purchase Agreement for each of the fiscal years ended December 31, 2015 and 2016. As of December 31, 2016 and 2015, SIL did not report positive EBITDA and therefore, no payment has been made on the contingent receivable.

As a result of the sale of our interest, we no longer have any ownership interest in SIL and have deconsolidated SIL from our consolidated financial statements. The results of operations of SIL are included in the accompanying consolidated financial statements through the date of the Unit Purchase Agreement. As of December 31, 2015, we recorded a gain of $189,000 on the sale, representing the difference between the consideration received and the carrying value of SIL's net assets at the time of the transaction, which is recorded in other expense (income) within the consolidated statements of operations.

4. Property and Equipment

Property and equipment, net, are comprised of the following ($ in thousands):

	December 31,	
	2016	2015
Computer equipment	$373	$341
Furniture and fixtures	192	232
Leasehold improvements	246	260
Website development and internal-use software	4,836	1,784
Total property and equipment	$5,647	$2,617
Less accumulated depreciation	1,625	613
Total property and equipment, net	$4,022	$2,004

Depreciation expense, including depreciation related to capitalized website development and internal-use software, was approximately $1.1 million and $329,000, respectively, for the years ended December 31, 2016 and 2015.

5. Goodwill and Intangible Assets

Goodwill

Goodwill has been recorded as a result of previous acquisitions. There were no additions to goodwill during the year ended December 31, 2016. See Note 2 for further discussion of our history of acquisitions. No losses on impairment of goodwill were recorded during the years ended December 31, 2016, or 2015. The carrying amounts as of December 31, 2016 and 2015 were $41.1 million.

Other intangible assets

Our other intangible assets arose primarily from the acquisitions described above and consist of a brand, the carrier network, distributor relationships, customer relationships, noncompete agreements and capitalized software. Finite-lived intangible assets are amortized over their useful lives from two to fifteen years.

Major classes of intangible assets, net as of December 31, 2016 consisted of the following ($ in thousands):

	Weighted-average Amortization (years)	Gross Carrying Amount	Accumulated Amortization	Intangible Assets, net
Brand	14.1	$ 1,377	$ (311)	$ 1,066
Carrier network	5.0	40	(40)	—
Distributor relationships	6.8	4,059	(2,831)	1,228
Noncompete agreements	4.7	987	(881)	106
Customer relationships	5.8	1,484	(1,125)	359
Capitalized software	6.7	8,571	(3,423)	5,148
Total intangible assets		$ 16,518	$ (8,611)	$ 7,907

Major classes of intangible assets as of December 31, 2015 consisted of the following ($ in thousands):

	Weighted-average Amortization (years)	Gross Carrying Amount	Accumulated Amortization	Intangible Assets, net
Brand	14.0	$ 1,377	$ (219)	$ 1,158

Carrier network	5.0	40	(35)	5
Distributor relationships	7.9	4,059	(2,234)	1,825
Noncompete agreements	4.7	987	(679)	308
Customer relationships	4.7	1,484	(1,019)	465
Capitalized software	6.6	8,571	(2,271)	6,300
Total intangible assets		$ 16,518	$ (6,457)	$ 10,061

Amortization expense for year ended December 31, 2016, and 2015 was $2.2 million and $2.6 million, respectively.

Estimated annual pretax amortization for intangibles assets in each of the next five years and thereafter are as follows ($ in thousands):

2017	$1,966
2018	1,725
2019	1,338
2020	1,338
2021	685
Thereafter	855
Total	$7,907

Reviews of other intangible assets are performed at each reporting period in accordance with GAAP. No impairments were noted during the year ended December 31, 2016. In connection with the 2015 restructuring, intangible assets were reviewed for impairment and as a result we recorded a loss on intangibles related to distributors of $878,000. The associated loss is included in the consolidated statement of operations as S, G & A expense for the year ended December 31, 2015. See Note 8 for further information on the restructuring.

6. Accounts Payable and Accrued Expenses

Accounts payable and accrued expenses as of December 31, 2016 and 2015 consisted of the following ($ in thousands):

	December 31,	
	2016	2015
Carriers and vendors payable	$11,385	$7,364
Commissions payable	5,710	3,830
Accrued wages	4,206	1,140
Accrued refunds	3,238	2,049
Accounts payable	928	670
Accrued professional fees	910	175
Accrued credit card/ACH fees	430	293
Accrued interest	—	3
Accrued restructuring	3	1,304
Other accrued expenses	2,870	1,019
Total accounts payable and accrued expenses	$29,680	$17,847

7. Debt

Revolving Line of Credit

On December 15, 2014, we entered into a three-year revolving line of credit (“RLOC”) for $15.0 million with a bank. The purpose of the RLOC is to provide working capital, expand the advanced commissions program, and to help us maintain adequate liquidity. Borrowings under this facility are secured by all of our and our subsidiaries’ assets, including, but not limited to, cash, accounts receivable, and property and equipment, net. The stated interest rate for the RLOC is 30-day LIBOR, plus 1.95%, which at December 31, 2016 and December 31, 2015 was 2.72% and 2.38%, respectively. As of December 31, 2016 we have no outstanding balance from draws on the RLOC and there is $15 million available to be drawn upon. As of December 31, 2015, we had drawn $7.5 million on the RLOC and had $7.5 million available to be drawn upon.

The RLOC is subject to customary covenants and restrictions which, among other things, require us to maintain minimum working capital equal to 1.50 times the outstanding balance, and require that our maximum funded debt to tangible net worth ratio shall not exceed 1.50 at any time during the term of the RLOC. The RLOC also imposes certain nonfinancial covenants on us that would require immediate payment if we, among other things, reorganize, merge, consolidate, or otherwise change ownership or business structure without the bank’s prior written consent. As collateral, there is a first position Uniform Commercial Code filing on all business assets.

The RLOC agreements also contain customary representations and warranties and events of default. The payment of outstanding principal under the RLOC and accrued interest thereon may be accelerated and become immediately due and payable upon default of payment or other performance obligations or failure to comply with financial or other covenants in the RLOC agreements, subject to applicable notice requirements and cure periods as provided in the RLOC agreements. As of December 31, 2016 and 2015, the Company was in compliance with all covenants of the RLOC agreement.

Under the terms of the RLOC, we incurred and capitalized certain costs related to acquiring the RLOC of $23,000. These costs consisted primarily of consulting and legal fees directly related to the bank loan. As of December 31, 2016 there was no balance of deferred financing costs. At December 31, 2015, the capitalized balance of the deferred financing costs of $15,000 were included in Accounts receivable, net, prepaid expenses and other current assets.

8. Restructuring

During the last quarter of the year ended December 31, 2015, the Company committed to and communicated a plan to restructure its operations at ICE and Secured. The Company determined the services of ICE and Secured to be duplicative and recognized that efficiencies could be gained by leveraging these operations with other owned call centers. As of December 31, 2015, the restructuring plan was communicated to employees and substantially complete.

No expense related to restructuring activities was recorded during the year ended December 31, 2016. As of December 31, 2016, the remaining liability associated with the restructuring is $3,000 and is included in the consolidated balance sheet as accounts payable and accrued expenses. The amount of expense incurred as of December 31, 2015 for the restructuring activities was $2.6 million and is included in the consolidated statement of operations as S, G & A expense. The Company had recorded a liability at December 31, 2015 of $1.3 million which is included in the consolidated balance sheet as accounts payable and accrued expenses.

In connection with the restructuring, intangible assets were reviewed for impairment and as a result of our assessment, we have recorded a loss on intangibles related to distributors of $878,000. for the year ended December 31, 2015. This loss is included with restructuring expenses in consolidated statement of operations as S, G & A expense. See Note 5 for further information on our intangible assets.

All liabilities associated with the restructuring approximate their fair values. All recorded liabilities are classified as current within the consolidated balance sheet.

9. Stockholders' Equity

On February 13, 2013, we completed our IPO by issuing 4,666,667 shares of our Class A common stock, par value $0.001 per share, at a price to the public of $14.00 per share of Class A common stock. In addition, we issued 8,666,667 shares of our Class B common stock, of which 8,580,000 shares of Class B common stock were obtained by HPI and 86,667 shares of Class B common stock were obtained by Health Plan Intermediaries Sub, LLC ("HPIS"), of which HPI is the managing member. In addition, we granted the underwriters of the IPO the right to purchase additional shares of Class A common stock to cover over-allotments (the "over-allotment option").

Our authorized capital stock consists of 100,000,000 shares of Class A common stock, par value $0.001 per share, 20,000,000 shares of Class B common stock, par value $0.001 per share, and 5,000,000 shares of preferred stock, par value $0.001 per share.

Class A Common Stock and Class B Common Stock

Each share of Class A common stock and Class B common stock entitles its holders to one vote per share on all matters to be voted upon by the stockholders, and holders of each class will vote together as a single class on all such matters. Holders of shares of our Class A common stock and Class B common stock vote together as a single class on all matters presented to our stockholders for their vote or approval, except as otherwise required by applicable law. As of December 31, 2016, the Class A common stockholders had 54.0% of the voting power in HII and the Class B common stockholders had 46.0% of the voting power in HII. Holders of shares of our Class A common stock have 100% of the economic interest in HII. Holders of Class B common stock do not have an economic interest in HII.

The determination to pay dividends, if any, to our Class A common stockholders will be made by our Board of Directors. We do not, however, expect to declare or pay any cash or other dividends in the foreseeable future on our Class A common stock, as we intend to reinvest any cash flow generated by operations in our business. We may enter into credit agreements or other borrowing arrangements in the future that prohibit or restrict our ability to declare or pay dividends on our Class A common stock. In the event of liquidation, dissolution or winding up of HII, the holders of Class A common stock are entitled to share ratably in all assets remaining after payment of liabilities, subject to prior distribution rights of preferred stock, if any, then outstanding. The holders of our Class A common stock have no preemptive or conversion rights or other subscription rights. There are no redemption or sinking fund provisions applicable to the Class A common stock. The rights, preferences and privileges of holders of our common stock will be subject to those of the holders of any shares of our preferred stock we may issue in the future.

Class B common stockholders will not be entitled to any dividend payments. In the event of any dissolution, liquidation, or winding up of our affairs, whether voluntary or involuntary, after payment of our debts and other liabilities and making provision for any holders of our preferred stock that have a liquidation preference, our Class B common stockholders will not be entitled to receive any of our assets. In the event of our merger or consolidation with or into another company in connection with which shares of Class A common stock and Class B common stock (together with the related membership interests) are converted into, or become exchangeable for, shares of stock, other securities or property (including cash), each Class B common stockholder will be entitled to receive the same number of shares of stock as is received by Class A common stockholders for each share of Class A common stock, and will not be entitled, for each share of Class B common stock, to receive other securities or property (including cash). No holders of Class B common stock will have preemptive rights to purchase additional shares of Class B common stock.

Exchange Agreement

On February 13, 2013, we entered into an exchange agreement (the "Exchange Agreement") with the holders of the Series B Membership Interests of HPIH ("Series B Membership Interests"). Pursuant to and subject to the terms of the Exchange Agreement and the amended and restated limited liability company agreement of HPIH, holders of Series B Membership Interests, at any time and from time to time, may exchange one or more Series B Membership Interests, together with an equal number of shares of our Class B common stock, for shares of our Class A common stock on a one-for-one basis, subject to equitable adjustments for stock splits, stock dividends and reclassifications.

Holders will not have the right to exchange Series B Membership Interests if we determine that such exchange would be prohibited by law or regulation or would violate other agreements to which we may be subject. We may impose additional restrictions on exchanges that we determine necessary or advisable so that HPIH is not treated as a "publicly traded partnership" for U.S. federal income tax purposes. If the Internal Revenue Service were to contend successfully that HPIH should be treated as a "publicly traded partnership" for U.S. federal income tax purposes, HPIH would be treated as a corporation for U.S. federal income tax purposes and thus would be subject to entity-level tax on its taxable income.

A holder that exchanges Series B Membership Interests will also be required to deliver an equal number of shares of our Class B common stock. In connection with each exchange, HPIH will cancel the delivered Series B Membership Interests and issue to us Series A Membership Interests on a one-for-one basis. Thus, as holders exchange their Series B Membership Interests for Class A common stock, our interest in HPIH will increase.

In accordance with the Exchange Agreement, in March 2013, we received a net amount of $1.4 million in proceeds from the issuance of 100,000 shares of Class A common stock through the over-allotment option. We immediately used the proceeds to acquire Series B Membership Interests, together with an equal number of shares of our Class B common stock, from HPI. These Series B Membership Interests were immediately recapitalized into Series A Membership Interests in HPIH.

On February 1, 2014, a registration statement on Form S-3 became effective under which we registered 8,566,667 shares of our Class A common stock for resale from time to time by the selling stockholder, of which all such shares are issuable upon the exchange of an equivalent number of Series B Membership Interests (together with an equal number of shares of our Class B common stock).

On August 15, 2014, we entered into an underwriting agreement with Raymond James & Associates, Inc., as the underwriter, and HPI and HPIS, as selling stockholders (the "Selling Stockholders"). Pursuant to the underwriting

agreement and an exchange agreement between the Company and Selling Stockholders (the “Exchange Agreement”) under which holders of Series B Membership Interests may exchange Series B Membership Interests, together with an equal number of shares of our Class B common stock, for shares of our Class A common stock on a one-for-one basis, we issued 1,725,000 shares of Class A common stock to the Selling Stockholders. We immediately acquired the Series B Membership Interests, together with an equal number of shares of our Class B common stock from the Selling Stockholders. These Series B Membership Interests were immediately recapitalized into Series A Membership Interests in HPIH. The Selling Stockholders agreed to immediately after the exchange sell to the underwriter for resale all 1,725,000 shares of Class A common stock at a public offering price of $12.15 per share ($11.54 per share, net of underwriting discounts), for net proceeds of $19.9 million. No shares were sold by the Company in this offering. The sale by the Selling Stockholders was made pursuant to a registration statement on Form S-3. No other shares of Class A common stock have been sold pursuant to the registration statement on Form S-3. The acquisition of the Series B Membership Interests resulted in a decrease in noncontrolling interests with an offsetting increase in stockholders’ equity as of December 31, 2014 to reflect the decrease in the noncontrolling interest’s investment in HPIH. See Note 15 for further discussion of this transaction’s effects on a tax receivable agreement we entered into with holders of Series B Membership Interests.

Preferred Stock

Our board of directors has the authority to issue shares of preferred stock in one or more series and to fix the rights, preferences, privileges and restrictions thereof, including dividend rights, dividend rates, conversion rights, voting rights, terms of redemption, redemption prices, liquidation preferences and the number of shares constituting any series or the designation of such series, without further vote or action by the stockholders.

The issuance of preferred stock may have the effect of delaying, deferring or preventing a change in control of HII without further action by the stockholders and may adversely affect the voting and other rights of the holders of Class A common stock. At present, we have no plans to issue any preferred stock.

Treasury Stock

Treasury stock is recorded at cost. As of December 31, 2016 and 2015, we held 119,544 and 150,993 shares of treasury stock, respectively, recorded at a cost of $1.1 million and $1.5 million, respectively.

Share Repurchase Program

On December 17, 2014, our Board of Directors authorized us to purchase up to 800,000 shares of our registered Class A common stock under a repurchase program which could remain in place until December 31, 2016. We have adopted a plan (the "Repurchase Plan") under Rule 10b5-1 of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), in connection with this authorization. The Repurchase Plan allows us to repurchase our shares of Class A common stock at times when we otherwise might be prevented from doing so under insider trading laws or self-imposed trading blackout periods.

During the year ended December 31, 2016 we made no repurchases under the Repurchase Plan. During the year ended December 31, 2015 we repurchased 73,852 shares of our registered Class A common stock under the Repurchase Program at an average price per share of $7.06.

Tax Obligation Settlements and Treasury Stock Transactions

Treasury stock is recorded pursuant to the surrender of shares by certain employees to satisfy statutory tax withholding obligations on vested restricted stock awards. In addition, certain forfeited stock based awards are transferred to and recorded as treasury stock, and certain restricted stock awards have been granted from shares in Treasury, and certain forfeited awards.

During the year ended December 31, 2016, 21,397 shares were transferred to Treasury as a result of surrendered shares of vested restricted stock awards and exercises of SARs, 43,600 shares were transferred to Treasury as the result of forfeitures of restricted stock awards, and 75,749 shares were granted to certain employees from Treasury as restricted stock awards. During the year ended December 31, 2015, 17,081 shares were transferred to Treasury as a result of surrendered shares of vested restricted stock awards, 164,132 shares were transferred to Treasury as the result of forfeitures of restricted stock awards, and 151,216 shares were granted to certain employees from Treasury as restricted stock awards. See Note 10 for further information on our Long Term Incentive Plan.

10. Stock-based Compensation

We maintain one stock-based incentive plan, the Health Insurance Innovations, Inc. Long Term Incentive Plan (the "LTIP"), which became effective February 7, 2013, under which SARs, restricted stock, restricted stock units and other types of equity and cash incentive awards may be granted to employees, non-employee directors and service providers. The LTIP expires after ten years, unless prior to that date the maximum number of shares available for issuance under the plan has been issued or our Board of Directors terminates this plan. At its inception, 1,250,000

shares of Class A common stock were reserved for issuance under the LTIP. In May 2016, the Company's shareholders approved an increase of 1,000,000 shares of Class A common stock and as of that date, there were 3,250,000 shares of Class A common stock reserved for issuance under the LTIP. As of December 31, 2015, there were 2,250,000 shares of Class A common stock reserved for issuance under the LTIP.

Restricted Stock

The vesting periods for grant recipients are at the discretion of the Compensation Committee of our Board of Directors and may be vested upon grant in whole or in part but generally have used a four-year period. Restricted stock units are amortized using the accelerated method over the vesting period.

The table below summarizes activity regarding unvested restricted stock under the LTIP during the years ended December 31, 2016 and 2015 (all amounts in thousands, except per share data):

	Number of Shares Outstanding	Weighted-Average Grant Date Fair Value (per share)	Aggregate Intrinsic Value
Restricted stock unvested at January 1, 2015	292	$ 12.25	$ 2,092
Granted	161	5.95	959
Vested	(88)	10.29	522
Forfeited	(164)	12.95	1,263
Restricted stock unvested at December 31, 2015	201	$ 7.50	$ 1,348
Granted	284	8.93	2,238
Vested	(56)	7.39	320
Forfeited	(43)	7.90	238
Restricted stock unvested at December 31, 2016	386	$ 8.52	$ 6,887

We realized income tax benefits of $57,000 and $100,000 from activity involving restricted shares for the years ended December 31, 2016 and 2015, respectively. The total fair value of restricted stock that vested for the years ended December 31, 2016 and 2015 was $413,000 and $885,000, respectively.

Stock Appreciation Rights

The SARs activity for the years ended December 31, 2016 and 2015 is as follows (all amounts in thousands, except per share data):

	SARs	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Term (in years)	Aggregate Intrinsic Value (a)
Outstanding at January 1, 2015	594	$ 12.37	6.1	$ —
Granted	1,145	4.69	—	—
Exercised (b)(c)	—	—	—	—
Forfeited or expired	(317)	11.44	—	3
Outstanding at December 31, 2015	1,422	$ 6.40	5.6	$ 2,238
Granted	909	7.34	—	—
Exercised (b)(c)	(35)	5.85	—	253
Forfeited or expired	(24)	4.95	—	26
Outstanding at December 31, 2016	2,272	$ 6.80	5.2	$ 25,105
Exercisable at December 31, 2016	1,570	$ 6.64	4.6	$ 17,605

(a) The intrinsic value of a SAR is the amount by which the market value of the underlying stock as of December 31, 2016, and 2015 exceeds the exercise price of the option multiplied by the number of shares represented by such SAR.

(b) Shares issued upon the exercise of SARs are treated as newly issued shares. There were 14,489 shares issued during 2016 related to exercises of SARs. There were no shares issued during 2015 related to exercises of SARs.

(c) There was no tax benefit recognized in 2016 or 2015 related to stock-based compensation for SARs.

During the year ended December 31, 2016, the weighted-average grant date fair value per share of stock-based compensation granted to employees during the period above was $3.68 per share. The total fair value of SARs that vested for the year ended December 31, 2016 was $3.1 million.

During the year ended December 31, 2015, the weighted-average grant date fair value per share of stock-based compensation granted to employees during the period above was $5.95 per share. The total fair value of SARs that vested for the year ended December 31, 2015 was $1.4 million.

Stock Options

The stock option activity for the years ended December 31, 2016 and 2015 is as follows (all amounts in thousands, except per share data):

	Stock options	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Term (in years)	Aggregate Intrinsic Value (a)
Outstanding at January 1, 2015	84	$ 12.13	8.3	$ 478
Granted	—	—	—	—
Exercised (b)(c)	—	—	—	—
Forfeited or expired	(5)	12.13	—	—
Outstanding at December 31, 2015	79	$ 1.07	7.3	442
Granted	—	—	—	—
Exercised (b)(c)	(39)	1.06	—	330
Forfeited or expired	—	—	—	—
Outstanding at December 31, 2016	40	$ 1.08	6.5	$ 668
Exercisable at December 31, 2016	31	$ 1.07	6.4	$ 521

(a) The intrinsic value of a stock option is the amount by which the market value of the underlying stock as of December 31, 2016, and 2015, exceeds the exercise price of the option multiplied by the number of shares represented by such stock option.

(b) Shares issued upon the exercise of stock options are treated as newly issued shares. There were 35,606 shares issued during 2016 related to exercises of stock options. There were no shares issued during 2015 related to exercises of stock options.

(c) There was no tax benefit recognized in 2016 or 2015 related to stock-based compensation for stock options.

During the year ended December 31, 2016 and 2015, no stock options were granted. The total fair value of stock options that vested for the years ended December 31, 2016 and 2015 was $269,000 and $508,000, respectively.

Accounting for Stock-Based Compensation

Expense for stock-based compensation is recognized based upon estimated grant date fair value and is amortized over the requisite service period of the awards using the accelerated method. We offer awards which vest based on service conditions, performance conditions, or market conditions. For grants of SARs and stock options, we apply the Black-Scholes option-pricing model, a Monte Carlo Simulation, or a lattice model, depending on the vesting conditions, in determining the fair value of share-based payments to employees. These models incorporate various assumptions, including expected volatility and expected term. Through November of 2015, expected stock price volatilities were estimated using implied volatilities of comparable publicly-traded companies, given our limited trading history. Since December 2015, volatility is calculated using the Company's trading history. The expected term of the awards represents the estimated period of time until exercise, giving consideration to the contractual terms, vesting schedules and expectations of future employee behavior. The Company uses its best estimate and the simplified method for "plain vanilla" awards under GAAP for calculating the expected term, where applicable. The risk-free interest rate is based on the U.S. Treasury yield curve in effect at the time of grant with an equivalent remaining term. Compensation expense is recognized only for those awards expected to vest, with forfeitures estimated based on our historical experience and future expectations. In accordance with GAAP, compensation expense is not recognized for awards with performance vesting conditions until it is deemed probable that the underlying performance events will occur. All stock-based compensation expense is classified within S, G & A expense in the consolidated statements of operations.

None of the stock-based compensation was capitalized during the years ended December 31, 2016 or 2015.

The Black-Scholes option-pricing model was used with the following weighted average assumptions for the years ended December 31, 2016 and 2015:

	Year Ended December 31,	
	2016	2015
Risk-free rate	1.4 %	1.5 %
Expected life	4.9 years	4.6 years
Expected volatility	58.7 %	44.3 %
Expected dividend	none	none

The following table summarizes stock-based compensation expense for the years ended December 31, 2016 and 2015 ($ in thousands):

	Year Ended December 31,	
	2016	2015
Restricted shares	$517	$495
SARs	3,174	553
Stock options	101	316
	$3,792	$1,364

The following table summarizes unrecognized stock-based compensation and the remaining period over which such stock-based compensation is expected to be recognized as of December 31, 2016 and 2015 ($ in thousands):

2016	**Unrecognized Expense**	Weighted Average Remaining years
Restricted shares	$ 2,086	2.1
SARs	1,492	2.0
Stock options	13	0.6
	$ 3,591	
2015		
Restricted shares	$ 673	1.8
SARs	1,531	1.8
Stock options	99	1.0
	$ 2,303	

These amounts do not include the cost of any additional awards that may be granted in future periods nor any changes in our forfeiture rate. There were 35,000 SARs and 35,606 stock options exercised during the year ended December 31, 2016. There were no SARs or stock options exercised during the year ended December 31, 2015.

11. Income Tax

The provision for income tax for the years ended December 31, 2016 and 2015, consisted of the following components ($ in thousands):

	Year Ended December 31,	
	2016	2015
Current:		
Federal	$3,295	$(6)
State	493	26
Total current taxes	3,788	20
Deferred:		
Federal	(7,736)	(1,265)
State	(803)	(677)
Total deferred taxes	(8,539)	(1,942)
Income taxes	$(4,751)	$(1,922)

The items accounting for differences between the income tax provision computed at the federal statutory rate and the provision for income tax for the years ended December 31, 2016 and 2015, was as follows:

	2016	2015
U.S. federal income tax rate	35.0 %	35.0 %
State income taxes, net of federal tax benefits	(0.1)	(2.7)
Valuation allowance	(51.6)	102.7
Operations of nontaxable subsidiary	(40.9)	131.0
Stock-based compensation contribution	(1.2)	38.2
Non-deductible or non-taxable items	2.0	(13.1)
Change in estimate of state effective tax rates	—	83.6
Return to provision adjustments	—	45.7
Income taxes	(56.8)%	420.4%

The deferred income tax assets consisted of the following as of December 31, 2016 and 2015 ($ in thousands):

	Year Ended December 31,	
	2016	2015
Deferred tax assets:		
Investment in subsidiary	$16,715	$18,724

Tax receivable agreement	3,789	386
Stock compensation	694	397
Net operating loss carryforwards	2,230	2,206
Allowance for doubtful accounts	4	15
Other	165	82
Total deferred tax assets	23,597	21,810
Less valuation allowances	(12,799)	(19,309)
Deferred tax assets, net of valuation allowance	10,798	2,501
Deferred tax liabilities:		
Identifiable intangible assets	(2,383)	(2,847)
Stock compensation	(225)	(8)
Other	(9)	(4)
Deferred tax assets (liabilities), net	$8,181	$(358)

At December 31, 2016, HII had no federal or state net operating loss carryforwards. At December 31, 2015, HII had $500,000 of federal net operating loss carryforwards, with varying amounts of state net operating loss carryforwards. Additionally, at December 31, 2016 and 2015, HP had approximately $5.7 million and $5.1 million, respectively, of federal and state net operating loss carryforwards with varying amounts of state net operating loss carryforwards for both years. These carryforwards are generally available through 2036 and start expiring in 2033.

HPIH is taxed as a partnership for income tax purposes; as a result, it is not subject to entity-level federal or state income taxation but its members are liable for taxes with respect to their allocable shares of each company's respective net taxable income. We are subject to U.S. corporate federal, state and local income taxes on our allocable share of net taxable income that is reflected in our consolidated financial statements.

The effective tax rate for the year ended December 31, 2016 was (56.8%) and the effective tax rate for the year ended December 31, 2015 was 420.4%. For the years ended December 31, 2016 and 2015, the benefit for income taxes were $4.8 million and $1.9 million, respectively. Deferred taxes on our investment in HPIH are measured on the difference between the carrying amount of our investment in HPIH and the corresponding tax basis of this investment. We do not measure deferred taxes on differences within HPIH, as those differences inherently comprise our deferred taxes on our external investment in HPIH.

Due to the ownership structure of HP, which is a taxable entity, it cannot join in a consolidated tax filing with HII. Consequently, its federal and state tax jurisdictions are separate from those of HII, which prevents deferred tax assets and liabilities of HII and HP from offsetting one another. The 2016 tax rate for HII was mainly impacted by the partial release of the deferred tax asset valuation allowance. HP's 2016 book loss generates a deferred tax benefit which is a major portion of the total tax benefit for HP. As a result, due to the offsetting effect of HP's pretax book loss and HII's pretax book income when the two are combined, the deferred tax benefit from HP along with the release of HII's valuation allowance results in a total combined effective tax rate of (56.8%). On a standalone basis, the effective tax rate for the year ended December 31, 2016 for HII was (39.2%), while the effective tax rate for the year ended December 31, 2016 for HP was 12.5%.

We evaluate quarterly the positive and negative evidence regarding the expected realization of net deferred tax assets. The carrying value of our net deferred tax assets is based on our assessment as to whether it is more likely than not that we will generate sufficient future taxable income to realize these deferred tax assets. We had recorded a valuation allowance against all of the deferred tax assets of HII as of December 31, 2015. We maintained a full valuation allowance on all of deferred tax assets of HII until December 31, 2016 when there was sufficient evidence to support the reversal of the eligible allowance. When we determined that we would be able to realize our remaining deferred income tax assets in the foreseeable future, a release of the related valuation allowance resulted in the recognition of $8.1 million of deferred tax assets at December 31, 2016. Significant management judgment is required in determining the period in which the reversal of a valuation allowance should occur. We considered all available evidence, both positive and negative, such as historical levels of income and future forecasts of taxable income, among other items, in determining whether a full or partial release of the valuation allowance was required. The timing of the release had been under more frequent review beginning with the first quarter of 2016 as the Company was emerging from a period of cumulative losses. However, in light of the pending HHS ruling, among other things, the Company did not have adequate positive evidence to support a release until the fourth quarter of 2016 when, among other things, the HHS rule became final. In addition, our assessments required us to schedule future taxable income in accordance with the applicable tax accounting guidance to assess the appropriateness of a valuation allowance which further required the exercise of significant management judgment. The release of the valuation allowance also resulted in the recognition of a $9.1 million tax receivable agreement obligation. See Note 15 for further information.

We account for uncertainty in income taxes using a two-step process. The first step is to evaluate the tax position for recognition by determining if the weight of available evidence indicates that it is more likely than not that the position will be sustained upon audit, including resolution of related appeals or litigation processes, if any. The second step requires us to estimate and measure the tax benefit as the largest amount that is more than 50% likely to be realized upon ultimate settlement. Such amounts are subjective, as a determination must be made on the probability of various possible outcomes. We reevaluate uncertain tax positions on a quarterly basis. This evaluation is based on factors including, but not limited to, changes in facts or circumstances, changes in tax law, effectively settled issues under audit, and new audit activity. Such a change in recognition and measurement could result in recognition of a tax benefit or an additional tax provision.

As of December 31, 2016 and 2015, respectively, we did not have a balance of gross unrecognized tax benefits, and as such, no amount would favorably affect the effective income tax rate in any future periods. For the year ended December 31, 2016 and 2015, respectively, there was no change to our total gross unrecognized tax benefit. We believe that there will not be a significant increase or decrease to the uncertain tax positions within 12 months of the reporting date. The Company accounts for interest and penalties associated with uncertain tax positions as a component of tax expense, and none were included in the Company’s financial statements as there are no uncertain tax positions outstanding as of December 31, 2016 and 2015, respectively. The Company’s 2013 through 2016 tax years remain subject to examination by tax authorities.

12. Net Income per Share

The computations of basic and diluted net income per share attributable to HII for the years ended December 31, 2016 and 2015 were as follows ($ in thousands, except share and per share data):

	Year Ended December 31,	
	2016	2015
Basic net income attributable to Health Insurance Innovations, Inc.	$4,513	$601
Weighted average shares—basic	7,599,533	7,524,566
Effect of dilutive securities:		
Restricted shares	89,126	57,261
SARs	176,801	1,795
Stock options	43,775	18,167
Weighted average shares—diluted	7,909,235	7,601,789
Basic net income per share attributable to Health Insurance Innovations, Inc.	$0.59	$0.08
Diluted net income per share attributable to Health Insurance Innovations, Inc.	$0.57	$0.08

Potential common shares are included in the diluted net loss per share calculation when dilutive. Potential common shares consist of Class A common stock issuable through restricted stock grants, stock options, and SARs and are calculated using the treasury stock method.

The following securities were not included in the calculation of diluted net income per share for the respective periods because such inclusion would be anti-dilutive (in thousands):

	Year Ended December 31,	
	2016	2015
Restricted shares	284	156
SARs	1,179	1,422
Stock options	—	3

Additionally, potential common stock totaling 6,841,667 shares at December 31, 2016 and 2015 issuable under an exchange agreement were not included in diluted shares because such inclusion would be antidilutive. See Note 9 for further details on the exchange agreement.

13. Fair Value Measurements

We measure and report financial assets and liabilities at fair value on a recurring basis. Fair value is defined as the exchange price that would be received for an asset or paid to transfer a liability (referred to as an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. Valuation techniques used to measure fair value must maximize the use of observable inputs and minimize the use of unobservable inputs. The fair value of our financial assets and liabilities is determined by using three levels of input, which are defined as follows:

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

The categorization of a financial instrument within the valuation hierarchy is based upon the lowest level of input that is significant to the fair value measurement.

We utilize the market approach to measure the fair value of our financial assets. As subjectivity exists with respect to many of the valuation techniques, the fair value estimates we have disclosed may not equal prices that we may ultimately realize if the assets are sold or the liabilities are settled with third parties. Below is a description of our valuation methods.

Contingent consideration for business acquisition. The contingent consideration related to the acquisitions of Secured and ASIA includes periodic cash payments, as described in Note 2, and are valued using external valuation specialists. The inputs include discount rates reflecting the credit risk, risk and the probability of the underlying outcome of the results required by the acquirees to receive payment and the nature of such payments. The underlying outcomes are subject to actual revenues and earnings relative to the target results in the respective instruments or agreement. These liabilities are included in Level 3 of the fair value hierarchy.

Noncompete obligation. Our noncompete obligation, an exclusivity agreement with the developer of A.R.I.E.S. as described in Note 15 are primarily valued using nonbinding market prices as stated in the agreement that are corroborated by observable market data. The inputs and fair value are reviewed for reasonableness and may be further validated by comparison to publicly available information or compared to multiple independent valuation sources. The noncompete obligation is classified within Level 2 of the fair value hierarchy.

The carrying amounts of financial assets and liabilities reported in the accompanying consolidated balance sheets for cash and cash equivalents, restricted cash, credit card transactions receivable, accounts receivable, advanced commissions, carriers and vendors payable, commissions payable, line of credit, and accounts payable and accrued expenses as of December 31, 2016 and 2015, respectively, approximate fair value because of the short-term duration of these instruments.

We recognize transfers between levels within the fair value hierarchy on the date of the change in circumstances that requires such transfer. We classify all of our contingent acquisition consideration as Level 3.

As of December 31, 2016, our liabilities measured at fair value were as follows ($ in thousands):

		Fair Value Measurement as of December 31, 2016		
	Carrying Value as of December 31, 2016	Level 1	Level 2	Level 3
Liabilities:				
Noncompete obligation	$ 110	$ —	$ 110	$ —
	$ 110	$ —	$ 110	$ —

As of December 31, 2015, our liabilities measured at fair value were as follows ($ in thousands):

		Fair Value Measurement as of December 31, 2015		
	Carrying Value as of December 31, 2015	Level 1	Level 2	Level 3
Liabilities:				
Noncompete obligation	$ 291	$ —	$ 291	$ —

Contingent acquisition consideration	532	—	—	532
	$ 823	$ —	$ 291	$ 532

A summary of the changes in the fair value of liabilities carried at fair value that have been classified in Level 3 of the fair value hierarchy was as follows ($ in thousands):

	Contingent Acquisition Consideration
Balance as of January 1, 2015	$ 4,400
Payments and settlements, net	(2,603)
Realized gain included in income	(1,265)
Balance as of December 31, 2015	$ 532
Payments and settlements, net	(532)
Realized gain included in income	—
Balance as of December 31, 2016	$ —

Realized and unrealized loss on the contingent acquisition consideration are included in fair value adjustment of contingent consideration on the accompanying consolidated statements of operations.

14. Segment Information

Operating segments are defined as components of an enterprise about which separate financial information is available that is evaluated regularly by the chief operating decision maker (“CODM”), or decision-making group, in deciding how to allocate resources and in assessing performance. During the three months ended March 31, 2015, we had two reportable segments: IPD and HP; however during the three months ended June 30, 2015, the structure of our organization changed such that our President and Chief Executive Officer became our named CODM. HP is viewed by our CODM as a component of the operations comprising the IPD segment. The CODM reviews our financial information in a manner substantially similar to the accompanying consolidated financial statements. As such, at December 31, 2016 and December 31, 2015, we had one reportable operating and geographic segment.

15. Commitments and Contingencies

Leases

We lease office space to conduct our operations which expire between 2017 and 2019. The office space operating lease agreements contain rent holidays and rent escalation provisions. Rent holidays and rent escalation provisions are considered in determining straight-line rent expense to be recorded over the lease term. The difference between cash rent payments and straight-line rent expense was $34,000 and $56,000 as of December 31, 2016 and 2015, respectively. Total rent expense under all operating leases, which includes equipment, was $504,000 and $684,000 for the years ended December 31, 2016 and 2015, respectively, and is included in S, G & A expenses in the accompanying consolidated statements of operations.

As of December 31, 2016, the future minimum lease payments under noncancellable operating leases were as follows ($ in thousands):

2017	$470
2018	294
2019	81
2020	—
2021	—
Total minimum lease payments	$845

BimSym Agreements

On August 1, 2012, the Company entered into a software assignment agreement with BimSym eBusiness Solutions, Inc. (“BimSym”) for our exclusive ownership of all rights, title and interest in the technology platform (“A.R.I.E.S. System”) developed by BimSym and utilized by us. As a result of the agreement, we purchased the A.R.I.E.S. System, our proprietary sales and member administration platforms, for $45,000 and this purchase was capitalized and recorded as an intangible asset. In connection with this agreement, we simultaneously entered into a master services agreement for the technology, under which we are required to make monthly payments of $26,000 for five years. After the five-year term, this agreement automatically renews for one-year terms unless we give 60 days’ notice.

Additionally, we also entered into an exclusivity agreement with BimSym whereby neither BimSym nor any of its affiliates will create, market or sell a software, system or service with the same or similar functionality as that of A.R.I.E.S. System under which we are required to make monthly payments of $16,000 for five years. The present value of these payments was capitalized and recorded as an intangible asset with a corresponding liability on the

accompanying consolidated balance sheets.

Tax Receivable Agreement

On February 13, 2013, we entered into a Tax Receivable Agreement ("TRA") with the holders of the HPIH Series B Membership Interests, which holders are beneficially owned by Michael W. Kosloske, our founder and Chief of Product Innovation. The TRA requires us to pay to such holders 85% of the cash savings, if any, in U.S. federal, state and local income tax we realize (or are deemed to realize in the case of an early termination payment, a change in control or a material breach by us of our obligations under the TRA) as a result of any possible future increases in tax basis and of certain other tax benefits related to entering into the TRA, including tax benefits attributable to payments under the TRA itself. This is HII's obligation and not an obligation of HPIH. HII will benefit from the remaining 15% of any realized cash savings. For purposes of the TRA, cash savings in income tax is computed by comparing our actual income tax liability with our hypothetical liability had we not been able to utilize the tax benefits subject to the TRA itself. The TRA became effective upon completion of the IPO and will remain in effect until all such tax benefits have been used or expired, unless HII exercises its right to terminate the TRA for an amount based on the agreed payments remaining to be made under the agreement or HII breaches any of its material obligations under the TRA in which case all obligations will generally be accelerated and due as if HII had exercised its right to terminate the agreement. Any potential future payments will be calculated using the market value of our Class A common stock at the time of the relevant exchange and prevailing tax rates in future years and will be dependent on us generating sufficient future taxable income to realize the benefit. Payments are generally due under TRA within a specified period of time following the filing of our tax return for the taxable year with respect to which payment of the obligation arises.

Exchanges of Series B Membership Interests, together with an equal number of shares of our Class B common stock, for shares of our Class A common stock, are expected to increase our tax basis in our share of HPIH's tangible and intangible assets. These increases in tax basis are expected to increase our depreciation and amortization deductions and create other tax benefits and therefore may reduce the amount of tax that we would otherwise be required to pay in the future. As of December 31, 2016, Series B Membership Interests, together with an equal number of shares of Class B common stock have been exchanged for a total of 1,825,000 shares of Class A common stock subsequent to the IPO. See Note 9 for further information on these issuances of Class A common stock. As a result of the exchanges noted above, we have recorded a liability of $10.0 million pursuant to the TRA as of December 31, 2016. We have determined that this amount is probable of being paid, because a portion of the deductions and other tax benefits noted above has been utilized based on our estimated taxable income for 2016 and future periods. This liability represents the share of tax benefits payable to the entities beneficially owned by Mr. Kosloske, if we generate sufficient taxable income in the future. Therefore we have also reversed the valuation allowance on our deferred tax assets related to the TRA. The exchange transactions created a tax benefit to be shared by the Company and the entities beneficially owned by Mr. Kosloske. As of December 31, 2016, we have made $672,000 of payments under the TRA. See Note 11 for further information on the income tax implications of the tax receivable agreement.

As of December 31, 2016, management decided to reverse the valuation allowance relating to the TRA agreement. This decision was based on 2015 and 2016 earnings, and the outlook of future earnings. The deferred tax asset relating to this agreement is expected to be fully realized in the future.

Distributor Advanced Commissions

As a course of business, we enter into agreements with our distributors to loan future commission payments based on actual sales, referred to as advanced commissions, net on the condensed consolidated balance sheets. Certain of these agreements may include a loan agreement and a UCC1 financing statement for the purposes of securing the future commission payments we make. Generally, these loans will be repaid to us by future commissions earned by the distributor based on actual sales, as described in the respective agreements.

On May 1, 2015, we entered into an agreement with HBO, and certain individuals and entities related to HBO to make advances via a variable secured promissory note (the “May 2015 Note”). The May 2015 Note provided for two advances of $500,000 each. As of December 31, 2015, the Company paid both advances totaling $1.0 million. The May 2015 Note, which secured the advances, matures on January 31, 2017 and bears interest only upon the occurrence of an event of default. All amounts outstanding, including interest, are due within thirty days of the maturity date, subject to acceleration upon the occurrence of an event of default. As of December 31, 2015, the outstanding balance was $1.0 million.

Under the May 2015 Note, HBO was eligible to earn production credits, beginning in January 2016, for each qualifying sale of our products, as defined in the May 2015 Note. Such production credits would be applied based on qualifying sales during each calendar quarter of 2016. Any such production credits earned during calendar year 2016 would be applied against the outstanding balance payable to us under the May 2015 Note in lieu of a cash payment to us but no amount would be payable by us to HBO. As of December 31 2016, there was no remaining balance under the May 2015 Note.

Legal Proceedings

The Company is subject to legal proceedings, claims, and liabilities that arise in the ordinary course of business. The Company accrues losses associated with legal claims when such losses are probable and reasonably estimable. If the Company determines that a loss is probable and cannot estimate a specific amount for that loss, but can estimate a range of loss, the best estimate within the range is accrued. If no amount within the range is a better estimate than any other, the minimum amount of the range is accrued. Estimates are adjusted as additional information becomes available or circumstances change. Legal defense costs associated with loss contingencies are expensed in the period incurred.

State Regulatory Examinations

Indiana Multistate Market Conduct Examination

The Company received notification in April 2016 from the Indiana Department of Insurance that a multistate examination had been commenced providing for the review of HCC Life Insurance Company's ("HCC") short-term medical plans, Affordable Care Act compliance, marketing, and rate and form filing for all products. In May 2016, the Company received notice that the Market Actions Working Group of the National Association of Insurance Commissioners determined that the examination would become a multistate examination. As the Company was a distributor of HCC products at that time, the notification indicated that the multistate examination will include a review of the activities of the Company and a review of whether the Company's practices are in compliance with Indiana insurance law and the similar laws of other states participating in the examination. The Indiana Department of Insurance is serving as the managing participant of the multistate examination, and the examination includes, among other things, a review of whether HCC (and the Company) has engaged in any unfair or deceptive acts or insurance business practices. At present, forty-two states have joined the multistate examination. On June 1, 2016, we responded to an initial document production request in this matter. In addition to the multistate examination led by Indiana, we are aware that several other states, including Florida, Ohio, and South Dakota are reviewing the sales practices and potential unlicensed sale of insurance by third-party distributor call centers utilized by the Company. The Company is not aware of any examination into the sales practices of the Company-owned call center, although the Company cannot be certain that no such investigation is occurring or will occur, and the Company is aware of and managing additional claims and inquiries that it does not believe are material at this time. Except as otherwise described below, it is too early to determine whether any of these regulatory examinations will have a material impact on the Company. The Company is proactively communicating and cooperating with all applicable regulatory agencies, and has provided a detailed action plan to regulators that summarizes the Company's newly developed and enhanced compliance and control mechanisms.

Montana Regulatory Action

The Company also received notification from the Office of the Montana State Auditor, Commissioner of Securities and Insurance ("CSI") that an administrative action has been initiated against it. The Company was among more than two dozen separate parties named by the CSI in a Notice of Proposed Agency Action on May 12, 2016, that alleges potential violations of the Montana Insurance Code. The Notice, directed to the Company as well as a large pool of third-party respondents ranging from very large companies to individual insurance agents, indicated that the CSI was concerned with the possibility of unfair trade practices, potentially unlicensed insurance practices, or agents that were not properly appointed to the insurance carriers for whom products were being offered. Seventeen of the named parties, including the Company, requested a hearing before the CSI to contest the state's allegations and, in addition to reviewing its own data, the Company has requested certain materials, data, and information from the CSI in order to do so. Pending the resolution of the matter, the CSI summarily suspended our license to conduct business in Montana. The state formally granted the Company's request to be heard on the issues, and a neutral Hearing Officer, experienced in the insurance industry, has been appointed to hear the matter. The Company has been cooperative with the CSI, and both parties have begun the routine exchange of information attendant to the hearing process so that the Company and the CSI can properly measure and gauge the potential of the allegations. Additional requests for information are ongoing as the Company works to understand the CSI's concerns.

While it is too early to assess whether the CSI's notice and the investigation of these organizations and individuals will have a material impact on us, based on the nature of the allegations and evidence provided by the CSI during the third and fourth quarters of 2016 and settlement discussions with the CSI in early 2017, we believe that a loss arising from the future assessment of a civil penalty against us in the range of $100,000 to $315,000 is probable but may vary based on the early stages of this matter. The Company and the CSI are in the process of attempting to reach a negotiated resolution and the Company will accrue funds for any settlement offers that it makes to the state. Both the Company and the CSI have expressed a willingness to explore amicable resolution options. To that end, the Company continues to regularly communicate, exchange information, and work closely with the CSI in furtherance of bringing the matter towards a mutually satisfactory resolution.

Massachusetts Regulatory Action

The Company also received notification of a civil investigative demand from the Massachusetts Attorney General's Office ("MAG") on June 16, 2016. As part of the MAG's regulatory oversight of the Massachusetts health care system and its corresponding authority to request documents from market participants, the MAG has requested certain information and documents from the Company. The information requested will be used to review the Company's sales and marketing practices, and ensure the Company is in compliance with Massachusetts laws and regulations. Additionally, the Company's materials and sales and marketing practices will be evaluated in order to ensure that they are neither deceptive nor do they constitute unfair trade practices.

The Company has provided all requested documents and materials and continues to cooperate with the MAG in order to bring the matter to an agreeable conclusion. Based on the nature of the allegations raised by the MAG and based on discussions with them, the Company believes a loss arising from the future assessment of a civil penalty is possible however, the Company has not received any formal settlement offer from the state. The Company has begun preliminary discussions with the MAG concerning resolution options to avoid the need and cost of a continuing inquiry, and the MAG has indicated it is willing to discuss such options; however, there is no guarantee that the parties will reach a mutually agreeable resolution. Any formal settlement proposal would need to be approved by the management of the MAG before it is presented to the Company and as such, the MAG will likely want to engage in additional discovery prior to doing so, and it is too early in the process to estimate a potential range of loss. The Company will accrue funds for any settlement offers it makes to the state.

Texas Regulatory Action

In September 2016, the Texas Department of Insurance (“TDI”) notified the Company that it has instituted an enforcement action to investigate alleged violations of advertising rules and third-party administrator license requirements in connection with the sale of the Company’s products. In connection with the investigation, the TDI requested certain information, records, and explanations and the Company delivered a response and the requested information and records in November 2016. Following such date, the TDI has not taken any action, and the TDI has only communicated that it is continuing to review the matter. The Company’s position is that there have been no violations of the advertising or third-party administrator statutes in Texas, although there is no assurance that the TDI will agree with position.

We are proactively communicating and cooperating with all regulatory agencies involved in the above-described examinations and actions and we have recently developed and enhanced our compliance and control mechanisms. However, it is too early to determine whether any of these regulatory matters will have a material impact on our business. Any adverse finding could result in significant penalties or other liabilities and/or a requirement to modify our marketing or business practices and the practices of our third-party distributors, which could harm our business, results of operations or financial condition. Moreover, an adverse regulatory action in one jurisdiction could result in penalties and adversely affect our license status or reputation in other jurisdictions due to the requirement that adverse regulatory actions in one jurisdiction be reported to other jurisdictions.

Miscellaneous

The Company has also received a number of private-party claims relating to alleged violations by its distributors of the federal Telephone Consumer Protection Act, alleging that their marketing activities were potentially unlawful. The Company is presently reviewing these matters and reviewing distributor compliance, and enhancing existing compliance. While these types of claims have previously settled or resolved without any material effect on the business, there is a possibility in the future that one or more could have a material effect. The Company requires that its distributors reimburse or indemnify it for any such settlements.

The Company has previously received inquiries but no claims, litigation, or findings of violation relating to alleged data loss and/or privacy breaches relating to affiliated companies. Each allegation is investigated upon receipt and handled promptly to resolution.

16. Employee Benefit Plan

We sponsor a benefit plan to provide retirement benefits for our employees, known as the Health Plan Int Holdings LLC 401(k) Profit Sharing Plan & Trust (the "Plan"). Participants may make voluntary contributions to the Plan from their annual base pre-tax compensation, cash bonuses, and commissions in an amount not to exceed the federally determined maximum allowable contribution amounts. For the years ended December 31, 2016, and 2015, the base maximum allowable contribution amount was $18,000, respectively. The Plan also permits for discretionary Company contributions. During the year ended December 31, 2016 the Company began offering discretionary contributions to participants for which the Company accrued $56,000. We made no discretionary contributions during the year ended December 31, 2015.

17. Related-Party Transactions

Health Plan Intermediaries, LLC

HPI and its subsidiary HPIS, which are beneficially owned by Mr. Kosloske, are related parties by virtue of their Series B Membership interests in HPIH, of which we are managing member. During the years ended December 31, 2016, and 2015, HPIH paid cash distributions of $2.0 million and $872,000, respectively, to these entities related to estimated federal and state income taxes, pursuant to the operating agreement entered into by HPIH and HPI. At December 31, 2016, the Company has accrued $2.8 million in distributions owed but not yet paid under the operating agreement. The distribution made during the year ended December 31, 2016 included no amount that was accrued as of December 31, 2015. The distribution made during the year ended December 31, 2015 included $229,000 that was accrued as of December 31, 2014.

Distributions by HPIH to its members

Pursuant to the operating agreement of HPIH, we determine when distributions will be made to the members of HPIH and the amount of any such distributions, except that HPIH is required by the operating agreement to make certain pro rata distributions to each member of HPIH quarterly on the basis of the assumed tax liabilities of the members.

Members of HPIH, including HII, incur U.S. federal and state income taxes on their allocable share of any net taxable income of HPIH. Net profits and net losses of HPIH are generally allocated to its members pro rata in accordance with the percentage interest of the units they hold. In accordance with the operating agreement of HPIH, we cause HPIH to make cash distributions to its members for purposes of funding their tax obligations in respect of the income of HPIH that is allocated to them. Generally, these tax distributions are computed based on our estimate of the net taxable income of HPIH allocable to the member multiplied by an assumed tax rate equal to the highest marginal effective

federal, state and local income tax rate applicable for an individual or corporation taking into account any allowable deductions. Additional amounts may be distributed to us if needed to meet our tax obligations and our obligations pursuant to the TRA. As of December 31, 2016, $2.8 million of distributions to its members was declared but unpaid and reported in due to member on the consolidated balance sheet.

Tax Receivable Agreement

As discussed in Note 15, on February 13, 2013, we entered into a tax receivable agreement with the holders of HPIH Series B Membership Interests, which are beneficially owned by Mr. Kosloske.

As of December 31, 2016, we are obligated to pay $10.0 million pursuant to the TRA, of which $521,000 is included in current liabilities and $9.5 million is included in long-term liabilities on the accompanying consolidated balance sheets. As of December 31, 2016, we have made payments under the TRA of $672,000. As of December 31, 2015, $748,000 was payable pursuant to the TRA, of which $342,000 was included in current liabilities and $406,000 was included in long-term liabilities on the accompanying consolidated balance sheets.

Reinsurance

Insurance carriers with which we do business often reinsure a portion of their risk. From time to time, entities owned or affiliated with Michael Kosloske, serve as reinsurers for insurance carriers that offer products sold by HPIH.

Health Benefits One, LLC

In October 2013, HPIH formed SIL with HBO, one of our distributors. See Note 3 for more information on this joint venture. HBO was a related party by virtue of its 50% ownership of membership interests in SIL. In March 2015, HPIH sold its interest in SIL to HBO, and HBO ceased being a related party. While HBO was considered a related party, during the three months ended March 31, 2015, we made net advanced commission payments of $907,000 and recognized $3.0 million of commission expense related to HBO. As of December 31, 2015, the advanced commissions balance related to HBO included in the accompanying consolidated balance sheets was $15.4 million.

18. Concentrations of Credit Risk and Significant Customers

Accounts receivable, net were $882,000 and $853,000 as of December 31, 2016 and 2015, respectively as is included as a component of accounts receivable, net, prepaid expenses, and other current assets in the accompanying consolidated balance sheets. As of December 31, 2016 we had two customers who made up approximately 43% of the net accounts receivable balance. As of December 31, 2015 we had four customers who made up approximately 54% of the accounts receivable, net balance.

Advanced commissions were $37.0 million and $24.5 million as of December 31, 2016, and 2015, respectively. For the year ended December 31, 2016, two distributors accounted for 65% and 16%, respectively, of our advanced commissions balance compared to 67% and 10%, respectively, for the year ended December 31, 2015.

Revenues consist of commissions earned for health insurance policies and discount benefit plans issued to members, enrollment fees paid by members, referral fees, and monthly administration fees paid by members as a direct result of enrollment services provided by us. None of our members individually accounted for 10% or more of the Company's revenue for the years ended December 31, 2016 or 2015.

For the year ended December 31, 2016, three carriers accounted for 60% of our premium equivalents and for the year ended December 31, 2015, two carriers accounted for 70% of our premium equivalents. For the year, HCC Life Insurance Company accounted for 22% of our premium equivalents, Unified Life Insurance Company accounted for 20%, and Companion Life Insurance Company accounted for 18%. The Company anticipates that its premium equivalents in 2017 will continue to be concentrated among a small number of carriers, although as a part of the Company's strategy of improving and increasing its product mix by seeking to add innovative new products, the Company anticipates that its carrier concentration may decrease.

The Company maintains its cash and cash equivalents at various financial institutions where we are insured by the Federal Deposit Insurance Corporation up to $250,000. The balances of these accounts from time to time exceed federally insured limits. The Company has not experienced any losses in such accounts. The Company believes it is not exposed to any significant credit risk on cash and cash equivalents.

19. Subsequent Events

On February 1, 2017, the Company came to mutual agreement with HCC Life Insurance Company, one of the Company's largest carriers, to terminate the terms of our carrier contract. The Company no longer sells HCC products through any of our distribution channels. The Company has strong carrier relations and the shift away from HCC is congruent with our strategy of driving continuous product innovation by diversifying our product portfolio and

developing relationships with new carriers to improve and increase our product mix. We do not expect this contract termination to have a material impact on our Company revenues although we can make no assurances that the replacement of HCC with new carriers will fully offset any revenue losses, if any, associated with the termination. For more information on our strategy, see Part I, Item 1 of this Annual Report on Form 10-K.

On February 9, 2017, the Company's former Chief Executive Officer, Patrick R. McNamee exercised 1.0 million SARs at the then NASDAQ Global Market close price of $19.75 resulting in the issuance of 753,197 shares of the Company's Class A common stock. The transaction accounts for a 9.2% increase in total issued Class A common stock from the December 31, 2016 reported balance. As of March 1, 2017 the Company had 8,914,717 shares issued and 8,795,173 shares outstanding.

SIGNATURES

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

HEALTH INSURANCE
INNOVATIONS, INC.

By: */s/ Gavin D. Southwell*
Gavin D. Southwell
President and Chief Executive Officer
(Principal Executive Officer)
March 2, 2017

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

DATE	SIGNATURE	TITLE
March 2, 2017	*/s/ Gavin D. Southwell* Gavin D. Southwell	President, Chief Executive Officer and Director (Principal Executive Officer)
March 2, 2017	*/s/ Michael D. Hershberger* Michael D. Hershberger	Chief Financial Officer, Secretary and Treasurer (Principal Financial and Accounting Officer)
March 2, 2017	*/s/ Michael W. Kosloske* Michael W. Kosloske	Director and Chief of Product Innovation
March 2, 2017	*/s/ Paul G. Gabos* Paul G. Gabos	Director
March 2, 2017	*/s/ Robert S. Murley* Robert S. Murley	Director

HEALTH INSURANCE INNOVATIONS, INC.

EXHIBIT INDEX

Exhibit No.	Description
2.1	Asset Purchase Agreement dated March 14, 2013, by and among Health Insurance Innovations, Inc., TSG Agency, LLC, and Ivan Spinner. Incorporated by reference to Exhibit 10.1 to Current Report on the Form 8-K filed March 14, 2013.
2.2	Stock Purchase Agreement, dated as of July 17, 2013, by and among Health Plan Intermediaries Holdings,LLC, Health Insurance Innovations, Inc., Joseph Safina, Howard Knaster and Jorge Saavedra (the schedules and exhibits have been omitted pursuant to Item 601(b)(2) of Regulation S-K). Incorporated by reference to Exhibit 2.1 to Current Report on Form 8-K filed July 23, 2013.
2.3	Agreement and Plan of Merger, dated July 14, 2014, among Health Insurance Innovations, Inc. SV Merger Sub, Inc., HealthPocket, Inc. Bruce Telkemp, Sheldon Wang, any Holder executing a Letter of Transmittal, Option Cancellation Agreement or Parent Option Agreement, and Randy Herman, as the Representative (all disclosure schedules to the Agreement and Plan of Merger have been omitted pursuant to Item 601(b)(2) of Regulation S-K). Incorporated by reference to Exhibit 2.1 to Current Report on Form 8-K filed July 16, 2014.
2.4	Membership Interest Purchase Agreement, dated August 8, 2014, between Health Plan Intermediaries Holdings, LLC and Landon A. Jordan (all disclosure schedules to the Membership Interest Purchase Agreement have been omitted pursuant to Item 601(b)(2) of Regulation S-K). Incorporated by reference to Exhibit 10.3 to Quarterly Report on Form 10-Q filed August 12, 2014.
3.1	Amended and Restated Certificate of Incorporation of Health Insurance Innovations, Inc. Incorporated by reference to Exhibit 3.1 to Current Reports on Form 8-K filed February 13, 2013.
3.2	Certificate of Correction to the Amended and Restated Certificate of Incorporation of Health Insurance Innovations, Inc. Incorporated by reference to Exhibit 3.2 to Current reports on Form 8-K filed February 13, 2013.
3.3	Amended and Restated Bylaws of Health Insurance Innovations, Inc. Incorporated by reference to Exhibit 3.3 to Current reports on Form 8-K filed February 13, 2013.
4.1	Registration Rights Agreement, dated February 13, 2013, among Health Insurance Innovations, Inc. and the stockholders named therein. Incorporated by reference to Exhibit 4.1 to Current Report on Form 8-K filed February 13, 2013.
4.2	Registration Rights Agreement, dated July 14, 2014, among Health Insurance Innovations, Inc. and Randy Herman, as Representative. Incorporated by reference to Exhibit 4.1 to Current Report on Form 8-K filed July 16, 2014.

10.1	Third Amended and Restated Limited Liability Company Agreement of Health Plan Intermediaries Holdings, LLC. Incorporated by reference to Exhibit 10.1 to Current Reports on Form 8-K filed February 13, 2013.
10.2	Tax Receivable Agreement among Health Insurance Innovations, Inc., Health Plan Intermediaries Holdings, LLC and Series B Members of Health Plan Intermediaries Holdings, LLC. Incorporated by reference to Exhibit 10.2 to Current Reports on Form 8-K filed February 13, 2013.
10.3	Exchange Agreement among Health Insurance Innovations, Inc., Health Plan Intermediaries Holdings, LLC and Series B Members of Health Plan Intermediaries Holdings, LLC. Incorporated by reference to Exhibit 10.3 to Current Reports on Form 8-K filed February 13, 2013.
10.4	Master Service Agreement between Health Plan Intermediaries, LLC and BimSym eBusiness Solutions, Inc. Incorporated by reference to Exhibit 10.8 to the Draft Registration Statement on Form S-1 (File No. 377-00034 / Film No. 121193612) filed November 9, 2012.
10.5	Software Assignment Agreement between Health Plan Intermediaries, LLC and BimSym eBusiness Solutions, Inc. Incorporated by reference to Exhibit 10.9 to the Draft Registration Statement on Form S-1 (File No. 377-00034 / Film No. 121193612) filed November 9, 2012.
10.6†	General Manager’s Agreement between Health Plan Intermediaries, LLC and Companion Life Insurance Company. Incorporated by reference to Exhibit 10.10 to the Second Submission to the Draft Registration Statement on Form S-1 (File No. 377-00034 / Film No. 121245775) filed December 6, 2012.
10.7	Marketing/Billing Agreement between Med-Sense Guaranteed Association and Health Insurance Innovations. Incorporated by reference to Exhibit 10.13 to the Second Submission to the Draft Registration Statement on Form S-1 (File No. 377-00034 / Film No. 121245775) filed December 6, 2012.

ExhibitNo.	Description
10.8#	Employment Agreement between Michael W. Kosloske and Health Insurance Innovations, Inc. Incorporated by reference to Exhibit 10.6 to Current Reports on Form 8-K filed February 13, 2013.
10.9#	Employment Agreement between Lori Kosloske and Health Insurance Innovations, Inc. Incorporated by reference to Exhibit 10.8 to Current Report on Form 8-K filed February 13, 2013.
10.10#	Health Insurance Innovations, Inc. Long Term Incentive Plan, as amended. Incorporated by reference to Exhibit 10.1 to Current Report on Form 8-K filed May 31, 2016.
10.11	Office Lease Agreement between Health Plan Intermediaries, LLC and Magdalene Center of Tampa, LLC. Incorporated by reference to Exhibit 10.22 to the Registration Statement on Form S-1 (File No. 333-185596 / Film No. 121278087) filed December 20, 2012.
10.12#	Form of Indemnification Agreement. Incorporated by reference to Exhibit 10.1 to Amendment No. 1 to Quarterly Report on Form 10-Q/A for the quarter ended March 31, 2013 filed August 13, 2013.
10.13#	Form of Restricted Stock Award Agreement. Incorporated by reference to Exhibit 10.2 to Amendment No. 1 to Quarterly Report on Form 10-Q/A for the quarter ended March 31, 2013 filed August 13, 2013.
10.14#	Form of Stock Appreciation Rights Award Agreement (Non-Employee Director; Stock-Settled). Incorporated by reference to Exhibit 10.3 to Amendment No. 1 to Quarterly Report on Form 10-Q/A for the quarter ended March 31, 2013 filed August 13, 2013.
10.15#	Employment Agreement between Health Insurance Innovations, Inc. and Bruce Telkamp. Incorporated by reference to Exhibit 10.1 to Current Report on Form 8-K filed July 16, 2014.
10.16#	Employment Agreement between Health Insurance Innovations, Inc. and Sheldon Wang. Incorporated by reference to Exhibit 10.2 to Current Report on Form 8-K filed July 16, 2014.
10.17	Agreement to Commercial Note, dated December 15, 2014, between Health Plan Intermediaries Holdings, LLC, and SunTrust Bank. Incorporated by reference to Exhibit 10.21 to Annual Report on Form 10-K filed March 18, 2015.
10.18	Commercial Note, dated December 15, 2014, by Health Plan Intermediaries Holdings, LLC in favor of SunTrust Bank. Incorporated by reference to Exhibit 10.22 to Annual Report on Form 10-K filed March 18, 2015.
10.19	Form of Security Agreement, dated December 15, 2014, by Health Plan Intermediaries Holdings, LLC and certain subsidiaries in favor of SunTrust Bank. Incorporated by reference to Exhibit 10.23 to Annual Report on Form 10-K filed March 18, 2015.
10.20	Form of Unconditional Guaranty, dated December 15, 2014, Health Plan Intermediaries Holdings, LLC and certain subsidiaries in favor of SunTrust Bank. Incorporated by reference to Exhibit 10.24 to Annual Report on Form 10-K filed March 18, 2015.
10.21#	

	Amendment, dated May 4, 2015, to Employment Agreement between Bruce Telkamp and Health Insurance Innovations, Inc. Incorporated by reference to Exhibit 10.1 to Current Report on Form 8-K filed May 5, 2015.
10.22#	Employment Agreement, dated June 8, 2015, between Health Insurance Innovations, Inc. and Patrick R. McNamee. Incorporated by reference to Exhibit 10.1 to Current Report on Form 8-K filed June 10, 2015.
10.23#	Form of Stock Appreciation Rights Award Agreement under Long Term Incentive Plan. Incorporated by reference to Exhibit 10.1 to Current Report on Form 8-K filed July 7, 2015.
10.24#	Form of Stock Appreciation Rights Award Agreement, dated July 1, 2015, granted to Bruce Telkamp and Sheldon Wang under Long Term Incentive Plan. Incorporated by reference to Exhibit 10.2 to Current Report on Form 8-K filed July 7, 2015.
10.25#	Second Amended and Restated Employment Agreement, dated September 16, 2015, between Michael Hershberger and Health Insurance Innovations, Inc. Incorporated by reference to Exhibit 10.1 to Current Report on Form 8-K filed September 22, 2015.
10.26#	First Amendment to Employment Agreement, dated November 9, 2015, between the Company and Patrick R. McNamee. Incorporated by reference to Exhibit 10.1 to Current Report on Form 8-K filed November 10, 2015.
10.27#	Stock Appreciation Rights Award Agreement, dated November 9, 2015, between the Company and Patrick R. McNamee under the Long Term Incentive Plan. Incorporated by reference to Exhibit 10.2 to Current Report on Form 8-K filed November 10, 2015.

ExhibitNo.	Description
10.28#	First Amendment to Employment Agreement, dated November 9, 2015, between the Company and Michael W. Kosloske. Incorporated by reference to Exhibit 10.3 to Current Report on Form 8-K filed November 10, 2015.
10.29#	Employment Agreement, dated July 24, 2015, between Health Insurance Innovations, Inc. and Josef Denother. Incorporated by reference to Exhibit 10.3 to the Form 10-Q filed August 8, 2016.
10.30#	Amendment to Employment Agreement, dated July 20, 2016, between Health Insurance Innovations, Inc. and Josef Denother. Incorporated by reference to Exhibit 10.4 to the Form 10-Q filed August 8, 2016.
10.31#	Second Amendment to Employment Agreement, dated July 20, 2016, between Health Insurance Innovations, Inc. and Patrick R. McNamee. Incorporated by reference to Exhibit 10.5 to the Form 10-Q filed August 8, 2016.
10.32#	Amended and Restated Employment Agreement, dated November 15, 2016, between Gavin D. Southwell and Health Insurance Innovations, Inc. Incorporated by reference to Exhibit 10.1 to Current Report on Form 8-K filed November 16, 2016.
10.33#	Separation Agreement and General Release, dated November 15, 2016, between Health Insurance Innovations, Inc. and Patrick R. McNamee. Incorporated by reference to Exhibit 10.2 to Current Report on Form 8-K filed November 16, 2016.
10.34#	Separation Agreement and General Release, dated November 15, 2016, between Health Insurance Innovations, Inc. and Josef Denother. Incorporated by reference to Exhibit 10.3 to Current Report on Form 8-K filed November 16, 2016.
21*	List of subsidiaries.
23*	Consent of Independent Registered Public Accounting Firm.
31.1*	Certification of Principal Executive Officer pursuant to Rule 13a-14(a).
31.2*	Certification of Principal Financial Officer pursuant to Rule 13a-14(a).
32*	Section 1350 Certifications.
100.INS	XBRL Instance Document.
101.SCH	XBRL Taxonomy Extension Schema Document.
101.CAL	XBRL Taxonomy Calculation Linkbase Document.
101.LAB	XBRL Taxonomy Label Linkbase Document.
101.PRE	XBRL Taxonomy Presentation Linkbase Document.
101.DEF	XBRL Taxonomy Definition Document.

*Document is filed with this Form 10-K.
#Indicates a management contract or compensatory plan or arrangement contemplated by Item 15(a)(3) of Form 10-K.

† The Registrant has received confidential treatment with respect to portions of this exhibit. Those portions have been omitted and filed separately with the Securities and Exchange Commission pursuant to a confidential treatment request.