Strategic Market Segmentation and Partnership Roadmap for Veron Care in the U.S. Health Insurance Sector (2024 - 2025)

Executive Summary and Strategic Imperatives (2024–2025)

The U.S. health insurance market is currently navigating a period of profound financial restructuring, demanding immediate and measurable returns on investment (ROI) from technology partners. For Veron Care, a non-contact radar health monitoring and fall detection system, the strategic imperative is to pivot the value proposition from a supplemental wellness offering to an essential financial de-risking asset, primarily targeting Medicare Advantage (MA) organizations. The convergence of rising medical costs, regulatory pressure, and the high financial burden of falls creates a mandatory investment climate for effective fall prevention technology.

Macroeconomic Headwinds and Payer Financial Contraction

The financial stability of the health insurance industry has diminished substantially, making cost control the paramount strategic objective for payers in 2024 and 2025. Data from the first six months of 2024 reveal a significant financial contraction, with the industry's aggregate underwriting gain decreasing by 31.3%, falling from

approximately $17.6 billion to $12.1 billion year-over-year [1]. This decline was compounded by a 14.1% decrease in net income over the same period [1].

The deterioration in profitability is rooted in escalating utilization rates. Total hospital and medical expenses surged by 7.4% in the first half of 2024, pushing the industry's loss ratio to 87.1% [1]. This pressure makes health plans highly conservative toward solutions that cannot guarantee a demonstrable reduction in utilization. Furthermore, the commercial market is exhibiting structural instability, with a projected acceleration of the shift from fully insured to self-insured models, particularly if premium costs continue to rise or an economic slowdown occurs [2]. Fully insured group enrollment is expected to drop from 53 million in 2023 to 49 million by 2028, while the self-insured segment is projected to increase from 110 million to 114 million over the same timeframe [2]. The combination of declining profits, rising costs, and shifting commercial enrollment mandates that Medicare Advantage payers, who manage bundled risk, invest exclusively in tools that offer a guaranteed, near-term financial payoff by mitigating major utilization events.

The Falls Crisis: A Quantifiable and Avoidable Financial Liability

Falls among adults aged 65 and older represent a catastrophic financial and clinical burden. They are the leading cause of fatal and non-fatal injuries in this population, contributing to over 36 million fall incidents annually and resulting in approximately $80 billion in medical costs for non-fatal fall injuries nationwide [3]. For healthcare systems, the financial liability is immense, as the average total cost of a single inpatient fall event is $62,521, with $35,365 attributed to direct costs alone [4].

The clinical literature confirms that investments in prevention are highly justified. Evidence-based falls prevention programs are demonstrated to yield compelling actuarial results, including a 52% reduction in the number of times participants fell, a 56% reduction in injurious falls, and an 18% reduction in fall-related emergency room (ER) visits [3]. The financial analysis supporting these programs estimates

that the projected return on investment (ROI) ranges from $8.36 to $38.04 for every dollar spent on falls prevention initiatives [3]. This extraordinary financial efficiency positions effective fall prevention technology, particularly a system like Veron Care, not as an optional benefit, but as a mandatory, capital-efficient expenditure. By preventing even a small number of high-cost fall events in an at-risk cohort, the cost avoidance far exceeds the implementation cost of the monitoring technology, resulting in a self-liquidating investment for the payer.

Veron Care's Strategic Differentiator in Passive Sensing

Veron Care's non-contact radar system directly addresses the primary failure point of traditional fall detection technology: patient non-compliance. Wearable devices, such as those offered by MobileHelp or Bay Alarm Medical [5], are frequently removed during high-risk activities like bathing or sleeping, compromising continuous safety monitoring. Veron Care's passive, non-contact approach eliminates this compliance risk, providing continuous oversight.

Technologically, the system aligns perfectly with requirements for remote patient monitoring (RPM) reimbursement. Medicare regulations require that monitored patients use an internet-connected device that meets the FDA's definition of a medical device and collects and transmits digital health data for a minimum of 16 days every 30 days [6, 7]. The system's passive data collection capability is inherently positioned to meet this 16-day requirement far more reliably than user-dependent devices. The market trend toward non-wearable solutions is already confirmed by competitive partnerships, such as Vayyar Care integrating its passive fall detection technology with Anthropos's Connected Care Platform [8], establishing a clear precedent for the viability of this solution.

U.S. Health Insurance Market Segmentation and Payer Prioritization

Veron Care's strategic execution must prioritize the Medicare Advantage (MA) segment, as its bundled payment structure and quality incentive programs (Star Ratings) create the most fertile environment for a high-ROI solution like non-contact monitoring.

Analysis of Market Segment Suitability

Market Segment	2024–2025 Enrollment Trend	Incentive Structure for Veron Care	Strategic Priority
Commercial	Fully insured declining (53M to 49M by 2028); Self-insured growing (110M to 114M) [2]	Diffuse; tied to voluntary wellness benefits and employee productivity, lacking direct clinical utilization risk bundling.	Low
Medicaid	Declining (6.5M loss in 2023; projection of 2.5M to 3M further loss by 2025) [2]	High concentration of high-risk dual-eligible members, but overall segment stability is low due to eligibility redeterminations.	Medium
Medicare Advantage (MA)	Steady growth (particularly duals) [2]	Direct financial incentive to reduce expensive utilization (Medical Loss Ratio); mandatory Star Ratings quality measures; existence	Highest

		of Special Supplemental Benefits (SSBCI).	

The MA segment is uniquely positioned because payers accept global risk for members, meaning every avoided hospital admission or ER visit directly improves the plan's Medical Loss Ratio (MLR). This direct financial linkage, coupled with regulatory incentives for quality, outweighs the diffuse ROI found in the highly fragmented commercial market.

Critical Payer Strategic Adjustments (2025–2026)

The current financial environment is leading to a dramatic consolidation and retrenchment among major MA carriers. Industry leaders, including UnitedHealthcare, Humana, and CVS Health's Aetna, are scaling back plan offerings for 2025 and 2026 [9, 10]. This is a direct response to financial pressures caused by rising healthcare costs and recent policy changes that are expected to result in significantly reduced government funding—with one executive estimating reimbursement cuts of 20% from 2023 levels by 2026 [9].

For instance, in 2025, Humana is decreasing its MA presence from 48 states to 46 states and reducing its county-level coverage from 89% to 85% nationwide [10]. Aetna is similarly contracting its market access [10]. This trend suggests that carriers are shedding less profitable or higher-risk areas and concentrating resources on their core profit zones. For Veron Care, this market behavior is not a signal of generalized weakness, but rather a guidepost: partnerships must focus on the plans and geographic areas that these carriers have chosen to retain, as these represent the most financially strategic and valuable parts of their portfolio where efficiency and cost avoidance are paramount.

Top Tier Corporate Client Analysis and Prioritization

The prioritization strategy targets the largest MA organizations which collectively insure nearly 60% of all MA beneficiaries, offering the necessary scale for a major technology partnership.

Table 2.3.1: Prioritized Target Client Segmentation (U.S. Medicare Advantage, 2024)

Insurer/Affiliate	**2024 MA Enrollment (Millions)**	**Key Strategic Mandate**	**Veron Care Focus Area**	**Priority Tier**
UnitedHealth Group (UHG)	9.4 - 9.5 [11, 12]	Quality Maintenance and Scale: Requires rigorous control to maintain high Star Ratings (78% of members projected in 4+ stars for 2026) [13].	Large-scale infrastructure integration for RPM deployment; optimization of Health Outcomes Survey (HOS) metrics.	Tier 1 (Volume and Quality Leadership)
Humana	6.0 - 6.1 [11, 12]	Efficiency and Focused Value: Strategic market reduction demands immediate	Deployment in Special Needs Plans (SNPs) and duals populations for demonstrab	Tier 1 (Cost Containment and Focus)

		MLR improvement and cost containment in retained markets [10].	le ER avoidance and utilization reduction.	
CVS Health (Aetna)	3.9 - 4.1 [11, 12]	Quality Improvement Catalyst: Need to lift mixed Star Ratings performance following portfolio consolidation.	Targeted interventions to rapidly improve HOS measures related to physical health and mental well-being [14].	Tier 2 (Quality Enhancement)
Blue Cross Blue Shield (BCBS Plans)	4.6 [11]	Regionalization and Provider Integration: Decentralized structure with strong local provider relationships.	Develop proof-of-concept models specifically with regional plans that possess mature Accountable Care Organization (ACO) or	Tier 2 (Provider and Geographic Access)

			value-based provider partnerships [15].	

Secondary Market: Long-Term Care (LTC) Insurance

Traditional Long-Term Care (LTC) insurers, such as Mutual of Omaha, New York Life, and Northwestern Mutual [16], represent an ancillary revenue stream that avoids the complexity of medical claims reimbursement. Many traditional LTC policies offer a cash benefit option, allowing the beneficiary to receive a set percentage of the monthly benefit to cover services supporting their plan of care, rather than only reimbursing specific incurred costs [17]. This flexibility allows policyholders to purchase and utilize non-contact monitoring systems without requiring the LTC insurer to integrate the technology into their claims processing or Durable Medical Equipment (DME) coverage. Veron Care should seek partnerships to be listed as a recommended technology within the "Care Coordination" services offered by these insurers [17].

Value Proposition and Strategic Fit Analysis

Veron Care's value proposition is strategically calibrated to address the two main financial levers available to MA payers: quality bonus revenue and avoided medical utilization costs.

Alignment with CMS Star Ratings: The Quality and Revenue Lever

Fall prevention is a critical component of the Medicare Advantage Star Ratings program, a metric calculated based on the percentage of at-risk patients (aged 65 or older) who received a fall risk intervention from their provider [18]. Success in this area is not merely academic; it directly impacts the MA plan's ability to earn substantial quality bonus revenue.

The regulatory environment is increasing the financial consequences of performance in this area. Health Outcomes Survey (HOS) measures, which include components related to physical function and mobility—often tied to fall risk—are scheduled to **triple in weighting by 2027** [14]. This shift elevates fall prevention to a central determinant of the plan's overall financial health. Traditional fall prevention methods, such as mailed informational materials or community classes, have historically demonstrated low impact and poor member utilization [14]. Veron Care's passive, non-contact intervention provides a reliable and scalable mechanism to guarantee a high rate of compliance for the "intervention received" metric, thus providing a consistent mechanism for payers to secure high marks on this critical quality measure.

Financial Impact: Avoided Costs and Payer ROI Modeling

The actuarial data supporting falls prevention is overwhelmingly favorable, showing projected cost savings per participant of $3,904.13 in the mean cost scenario, leading to a projected ROI ranging from $8.36 to $38.04 for every dollar invested [3].

The underlying cost structure of fall events further strengthens this value proposition. Economic evaluations of inpatient falls demonstrate that the average total cost of a fall is substantial ($62,521) and that injury status was not found to be significantly associated with increased costs [4]. This key finding indicates that the overwhelming cost is driven by the initial trauma response, diagnostics, observation time, and triage process, regardless of the final injury severity. Veron Care's non-contact system, providing immediate and accurate identification of a fall event (or lack thereof), allows for rapid and correct triage. This capability enables

care coordinators to potentially bypass the high-cost ER or inpatient pathway for non-injurious or minor events, maximizing the financial value of the intervention through cost avoidance. This process is expected to contribute to the documented potential of an 18% reduction in fall-related ER visits [3].

Mitigation of Hospital Readmissions Reduction Program (HRRP) Penalties

Medicare Advantage plans and their affiliated health systems share a common financial goal: avoiding penalties under the Hospital Readmissions Reduction Program (HRRP). This Medicare value-based program reduces payments to hospitals for excess readmissions related to conditions such as Acute Myocardial Infarction (AMI), Chronic Obstructive Pulmonary Disease (COPD), and Heart Failure (HF) [19]. Penalties can be significant, potentially amounting to up to 3% of a hospital's total Medicare reimbursement [20].

High-risk patients discharged from the hospital often fall at home, leading to expensive and avoidable 30-day readmissions. Deploying Veron Care as part of a post-discharge or Transitional Care Management (TCM) strategy allows the MA payer and the provider to gain continuous, objective, passive oversight of the member's activity levels and safety in the high-risk post-acute window. This positions the technology as an essential solution for preventing readmission-triggering events, directly mitigating shared financial risk under bundled payment arrangements.

Regulatory Pathways and Competitive Landscape

Veron Care must align its operational model with two distinct CMS mechanisms to secure widespread adoption: professional fee-for-service reimbursement (RPM) and MA benefit design (SSBCI).

Reimbursement Pathway 1: Remote Patient Monitoring (RPM)

The non-contact system is well-suited to meet the technical requirements for RPM billing, enabling providers to capture revenue associated with monitoring services. To qualify for Medicare reimbursement, the system must function as an internet-connected device that meets the FDA's definition of a medical device [6] and must collect and transmit physiologic data for a minimum of 16 days out of a 30-day period [7].

The passive nature of the radar system provides a significant compliance advantage. Unlike wearable devices, which often fail to meet the 16-day monitoring threshold due to user non-compliance, Veron Care's continuous, non-user-dependent data collection ensures reliable attainment of the threshold. This makes it easier for providers to bill for the service accurately [21]. While regulatory stability remains a concern, particularly regarding the potential expiration of broad telehealth flexibilities after September 30, 2025 [22, 23], RPM reimbursement is primarily governed by device criteria and data collection mandates, offering a comparatively resilient regulatory path.

Reimbursement Pathway 2: Special Supplemental Benefits for the Chronically Ill (SSBCI)

MA plans can offer Special Supplemental Benefits for the Chronically Ill (SSBCI) to members who meet a strict three-pronged definition: having complex chronic conditions, possessing a high risk of adverse health outcomes (like hospitalization), and requiring intensive care coordination [24].

Veron Care is highly applicable under this pathway, classified as a non-primarily health-related benefit (Non-PHRB). It fits the descriptions of "Equipment and Services" or "Structural Home Modifications" designed to improve or maintain the function and overall health of a chronically ill enrollee in their home environment [25]. This mechanism is crucial because it allows payers to deploy the technology non-uniformly, targeting only their highest-cost, highest-risk SSBCI-eligible populations, thereby maximizing the fall-avoidance ROI where it is needed most [24].

Furthermore, a new regulatory requirement finalized in the Contract Year 2025 Final Rule (42 CFR § 422.2267) requires MA plans to provide detailed mid-year communications listing unused supplemental benefits, including scope and access details [26]. Veron Care can leverage this new operational burden as a sales lever by offering turnkey administrative support and streamlined reporting for the deployment and utilization of the SSBCI benefit, making the solution an administrative asset as well as a clinical one.

Competitive Analysis and Clinical Credibility

The non-contact fall detection segment is mature enough to have established competitors and successful partnership models. For example, Vayyar Care has partnered with Anthropos's Connected Care Platform [8], and FallCall Solutions has collaborated with Ranix for specific use cases like hospital bed monitoring [27]. This confirms the viability and growing demand for radar-based passive sensing.

However, success in the high-stakes value-based care (VBC) market is contingent upon robust clinical validation. Healthcare stakeholders, including payers and investors, are increasingly prioritizing digital health solutions that possess strong clinical evidence of efficacy and safety, demonstrated through trials and published research [28]. To secure competitive risk-sharing contracts, Veron Care must prioritize obtaining published data that validates the system's accuracy, latency, and, most importantly, its ability to yield measurable reductions in adverse clinical outcomes such as fall incidence and subsequent ER utilization within MA-relevant

cohorts. This evidence is the primary currency for negotiating sophisticated partnership agreements.

Partnership Strategy and Execution Playbook

The optimal partnership strategy for engaging top-tier MA carriers requires a phased approach that minimizes initial payer risk and scales based on proven financial performance metrics.

Phased Partnership Models for MA Carriers

Partnerships should progress through two distinct phases, starting with validation and culminating in full financial risk alignment:

Phase 1: Diagnostic Proof-of-Concept (POC)

The initial phase should be designed to establish the technology's effectiveness and the financial baseline. This typically involves a limited, geographically focused cohort of 500 to 1,000 SSBCI-eligible MA members, who represent the highest-risk group [29]. The financial model for this phase is a fixed-fee for technology deployment, installation, and data services. A key objective in this phase is securing payer cooperation to access historical claims data for the cohort, which is essential for accurately calculating the pre-intervention baseline for fall rates, ER usage, and hospitalizations, mitigating the challenge of data availability often faced in VBC arrangements [30].

Phase 2: Full-Scale Value-Based Contracting (VBC) / Shared Savings

Upon successful validation of clinical and financial performance in the POC, the partnership transitions to a large-scale deployment across high-risk MA populations. The core financial model should be a Shared Savings Agreement. Under this model, Veron Care's compensation is directly tied to achieving predefined Key Performance Indicators (KPIs) that result in utilization reduction compared to the established baseline [31]. This risk-sharing framework is highly attractive to payers, particularly during periods of financial strain, because payment is contingent upon proven success. Startups can leverage their high ROI potential to negotiate more competitive pricing and flexibility than established technology firms might offer [32].

VBC Key Performance Indicators (KPIs) and Financial Metrics

Contractual agreements must meticulously define the metrics that govern shared savings, ensuring alignment between Veron Care's service delivery and the payer's primary financial and regulatory goals.

Table 5.2.1: Veron Care Value-Based Key Performance Indicators (KPIs) for Payer Contracts

Payer Value Metric	**Strategic Rationale**	**Veron Care Contribution**	**Target KPI Range**
Injurious Fall Incidence Rate Reduction	Direct reduction in catastrophic medical costs and improvement in HOS-related quality metrics.	Passive continuous monitoring leading to early intervention and risk mitigation.	50% Reduction vs. Baseline [3]

Fall-Related ER Visits/Hospitalizations Reduction	Reduces acute, high-cost utilization events and directly improves the Medical Loss Ratio (MLR).	Rapid, accurate detection and triage allows unnecessary transfers to acute care settings to be avoided.	18% Reduction vs. Baseline [3]
MA Star Ratings: Fall Risk Intervention Measure Compliance (HOS)	Secures CMS quality bonus revenue, essential for competitive positioning.	Ensures high compliance rate for the required "intervention received" metric, mitigating the low compliance of traditional methods.	Achieve 4+ Stars on measure for participating cohort [18]
30-Day Readmission Reduction (TCM)	Reduces hospital financial penalties imposed by the HRRP, strengthening payer-provider relationships.	Continuous post-discharge safety and activity monitoring in the home environment.	Reduction of 1-3% in related Excess Readmissions Ratio (EXRR) [20]

Operational Integration and Data Strategy

Successful implementation of RPM within a VBC framework requires robust integration and minimal administrative burden on participating providers. The passive radar system must be designed to integrate seamlessly with existing Electronic Health Records (EHRs) used by the payer's physician network. Furthermore, the system must automate regulatory reporting, specifically by confirming that the critical 16-day minimum monitoring threshold for RPM billing codes is met. This commitment to reducing administrative friction for the provider side is essential for maximizing adoption and ensuring compliance with CMS requirements [21]. Providing the payer with comprehensive, real-time data on member activity and safety—data that is often inaccessible due to patient leakage—constitutes an additional, high-value offering that enhances the payer's ability to manage population health risk [30].

Conclusions and Recommendations

The 2024–2025 U.S. health insurance landscape is characterized by severe financial pressure and intense regulatory focus on quality outcomes, making it a critical window for technologies that offer clear financial de-risking. Veron Care's non-contact radar system provides a uniquely positioned solution to address the high-cost, high-visibility problem of falls in the elderly population.

The analysis confirms that the MA market represents the highest priority, specifically targeting Tier 1 carriers—UnitedHealth Group and Humana—who are driven by imperatives of scale and profitability consolidation, respectively. The documented return on investment for fall prevention (ranging from $8 to $38 per dollar spent) provides the compelling actuarial justification required for immediate capital expenditure by these major carriers.

The recommended strategic roadmap involves:

1. **Prioritizing VBC Contracts:** Focus all sales efforts on establishing Shared Savings Agreements with top-tier MA payers, beginning with fixed-fee Proof-of-Concept pilots leveraging the SSBCI pathway to target the highest-risk members.
2. **Marketing as a Star Ratings Tool:** Position the system primarily as a compliance solution that guarantees achievement of the mandatory fall risk intervention quality measure, mitigating the financial threat posed by the anticipated tripling of HOS measure weighting by 2027.
3. **Securing Clinical Validation:** Invest immediately in publishing clinical data that validates the system's efficacy in reducing fall incidence and ER utilization within an MA cohort. This evidence is non-negotiable for securing favorable risk-sharing terms and overcoming adoption hesitancy.
4. **Enabling Provider Revenue:** Ensure seamless operational integration and simplified reporting to help physician partners maximize their potential revenue capture through existing Remote Patient Monitoring (RPM) CPT codes, thus driving adoption from the provider network upward to the payer.