Waybright

WARRANTY-BACKED MATERNITY NAVIGATION FOR SELF-FUNDED EMPLOYERS

Partner White Paper

Why warranty-backed episode navigation is the right model for commercial maternity in 2026.

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EXECUTIVE SUMMARY

The argument, in one page.

Maternity is the most expensive predictable episode in your benefits plan. The average commercial maternity episode now costs $20,416.[4] Roughly one in ten newborns goes to the NICU at an average admission cost of $71,158.[5] C-section rates run from 13% to 83% across hospitals in the same metropolitan area. Postpartum depression is identified at the six-week visit in fewer than 60% of cases where it is present. Maternity sits at roughly 12% of total cost of care for a typical commercial population, and at any given moment it is the single most actionable line item in the medical book. None of this is news to your actuary.

What is new is that the variability is measurable, the failures are preventable, and most of the recoverable dollars sit in two levers a navigator can pull without delivering any care: steering members away from high-intervention facilities, and catching NICU risk early enough to change the trajectory. Waybright is built to pull those levers, and to pay the cost of the readmissions it should have prevented when it misses.

Waybright is a maternity episode navigation service for self-funded employers, built on three components no current competitor combines into a single offer: one named navigator from confirmation through twelve weeks postpartum, on claims-integrated risk stratification at intake; facility-level steering using published outcomes data, surfaced before the third trimester, the single largest dollar lever in the model; and a 30-day readmission warranty under which Waybright pays the cost of the second episode, out of its own reserves, if a navigated member is readmitted for a pregnancy-related cause. Not a fee refund. Payment of the claim.

This document is written for the person who has to defend the line item, not the person who has to use the service.

The warranty is the operator forcing function. Everything upstream of it — the navigator, the claims integration, the facility steering, the screening protocol — is the work the warranty makes us actually do.

THE PROBLEM

Twenty-eight people. No one accountable for the whole.

A typical commercial pregnancy episode touches twenty-eight distinct billing entities: obstetricians, maternal-fetal medicine specialists, hospitals, labs, ultrasound centers, anesthesiologists, pediatricians, lactation consultants, behavioral health, pharmacy. None sees the whole episode. None is responsible for the outcome. The member is the only person tracking everything, and she is the least equipped to do it. The system has so thoroughly diffused the work of navigation that it has also diffused the responsibility.

When responsibility is diffuse, three things happen. Risk that should be identified at intake gets identified at symptom presentation, when the intervention window is closing. Site-of-care decisions default to whichever hospital the OB delivers at, regardless of that facility's published C-section rate or NICU level. And postpartum screening happens at the six-week visit if it happens at all, so the leading category of pregnancy-related maternal mortality — mental health conditions[3] — goes undetected until it presents as crisis. These are not failures of clinical judgment. They are failures of structure.

Why current navigation doesn't move outcomes.

Standard maternity navigation runs on three structural choices that cap how much outcome change is achievable. Navigators rotate from call to call, so no relationship deepens. Risk stratification is self-reported, so the highest-risk members — the ones most likely to underreport — are systematically undermanaged. And no party is contractually accountable for the outcome, so nothing forces the upstream work to get done.

Newer competitors have begun to address continuity and the risk model. Pomelo Care's published outcomes — a 37% reduction in preterm births and a 6.8-day reduction in NICU length of stay[9] — show that focused, claims-integrated navigation moves clinical outcomes meaningfully. The category is no longer empty. What it still lacks is a navigator that pays the downstream cost when it misses.

THE MODEL

What we built, and why this shape.

Waybright pairs three components that already exist somewhere in the market with a fourth that does not. Together they produce a service that can be evaluated against your own baseline, not against a vendor's selectively published numbers.

COMPONENT ONE

Named navigation

One RN-level navigator from the first OB claim through twelve weeks postpartum, with the member's full claims history reviewed before the first conversation. Proactive touchpoints at weeks 12, 20, 28, 32, 36, weekly from 37, and at 2, 6, and 12 weeks postpartum. The point of continuity is not warmth; it is that the navigator who reviewed the intake stratification is the same person managing the third-trimester decision and the postpartum screening, so information stops getting lost in handoffs.

COMPONENT TWO

Claims-integrated risk stratification

Every enrolled member is scored against published clinical decision rules at intake: ACOG screening rules and pre-pregnancy A1C for gestational diabetes, USPSTF aspirin guidelines and prior-pregnancy claims signals for preeclampsia, maternal-fetal medicine claims patterns for NICU risk, pre-pregnancy mental health claims for postpartum depression. The screening calendar is shaped around the risk profile, not the standard week-24 test or six-week visit. On top of the rules, a machine learning model trained on commercial claims surfaces patterns the rules miss. The model is the navigator's clinical co-pilot. It flags. The navigator decides. We do not use AI to replace clinical judgment; we use it to give one person the pattern-recognition reach of a team.

COMPONENT THREE

Facility-level steering

Before the third trimester, the navigator surfaces the C-section rate, NICU level, and case mix index for every facility the member's OB delivers at. Decision support, not directive. The data is publicly reported through the Leapfrog Group and CMS hospital surveys; what is novel is putting it in front of the member at the moment it matters, in a form she can use. This is the largest single dollar lever in the model, and it saves money whether or not the warranty ever fires.

COMPONENT FOUR

The warranty

If a Waybright-navigated member is readmitted within thirty days of delivery for a pregnancy-related cause, Waybright pays the cost of the second episode at full plan-allowed amount, directly against the claim, out of its own reserves. Not a refund of Waybright fees. Not a credit toward next year. Payment of the claim. The warranty is contractual, reserved against on our books at the conservative end of new-product-line precedent, and audited quarterly. The full mechanics are documented in our separate warranty white paper.

These four components together are the product. There is no tier that locks features behind a paywall. There is no upsell.

THE STRUCTURAL ARGUMENT

We attest, and we post a bond.

The reason the warranty means something is structural, and it is the heart of why Waybright is not a smaller version of the companies you already know.

Waybright does not deliver your members' care. Their OB stays their OB. Their hospital stays their hospital. We are the independent layer accountable for the episode, and we reserve capital against what gets missed. The entity reserving against the miss is independent of the entity that delivered the care. That independence is not a feature. It is the thing that makes the commitment credible.

An auditor attests to a result it did not produce. That independence is the entire reason the attestation is worth anything. After Enron, the law forbade the auditor from also being the consultant, because an entity grading its own work cannot be trusted to grade it honestly. The same logic governs maternity outcomes. A value-based provider that delivers the care and reports its own outcomes is grading its own test. The incentive to upcode, to over-treat, to steer toward its own facilities is structural, not a question of good faith. Waybright has no downstream economic interest in what care gets delivered, because we deliver none of it. We have one economic interest: that the episode goes well, because we pay when it doesn't.

THE TWO-SIDED CLAIM

We **attest** — we report outcomes against your own historical baseline, a number your CFO already has and already trusts, not a modeled control group of our choosing. And we **post a bond** — we pay the cost of the readmissions we should have prevented. An auditor only attests. A value-based provider only delivers. Waybright is the only model we have found that attests to a result it did not produce and posts a bond against it.

THE WARRANTY

Why we stake the outcome.

Maternity is among the most measurable, most predictable, and most clinically actionable episodes in the benefits plan. A navigation service that cannot be held contractually accountable for the outcome is not navigation. It is a call center with software.

We stake the warranty for three reasons. First, it forces internal discipline: every screening that should happen either happens or is documented as missed — and when a miss becomes a covered readmission, the cost flows to us. Second, it inverts the diligence burden — instead of asking you to trust our outcomes pitch, the warranty asks us to trust our own. Third, it produces a quarterly signal, warranty payouts against expected, that is more diagnostic of operational quality than any engagement metric a competitor can show you.

What the warranty covers, and what it doesn't.

Pregnancy-related causes include postpartum hemorrhage, C-section wound infection, hypertensive emergency including preeclampsia rebound, endometritis, and delivery-related DVT and PE. Exclusions cover unrelated injury, pre-existing chronic condition flares unrelated to pregnancy, and outpatient-to-observation escalations without a coded pregnancy-related cause. Postpartum mental health admissions are excluded at launch and re-added after twenty-four months of base obstetric warranty experience; the navigator still screens for postpartum depression, surfaces the PSI, and coordinates care throughout. Member care is unchanged. The full inclusion and exclusion framework, with adjudication procedure, is in the warranty white paper.

On how it's priced.

Waybright charges a single blended PEPM. We do not price the warranty as separate insurance and we do not describe it as risk transfer, because it is not priced as risk transfer. The warranty commitment is funded inside the blended fee, deliberately above bare expected loss, the same way every durable warranty is priced, because the price funds the work that makes claims rare, not merely the claims. The reserve methodology and the full pricing posture are documented for your actuary in the warranty white paper. The honest one-line version: we are not selling you an insurance policy at an actuarial premium; we are holding risk against our own work, priced so that holding it is sustainable and missing is expensive to us.

THE NUMBERS ILLUSTRATIVE · PENDING ACTUARIAL CERTIFICATION

Steering leads. The warranty is the floor under it.

The figures below are for an illustrative 10,000-employee self-funded employer generating roughly 220 pregnancies per year, at a blended $6.00 PEPM ($720,000 annual). Every figure derives from published sources, cited at the end. Send your own baseline and we return your numbers.

Read the dollar case in order. NICU avoidance is the largest lever in this book; facility steering is the second and the most operationally portable; the readmission warranty is the third, and the smallest in dollars. Its value is not the savings it generates but the discipline it forces and the protection it provides when the first two levers miss.

GROSS MODELED SAVINGS BY LEVER — ILLUSTRATIVE 10,000-EMPLOYEE BOOK (220 PREGNANCIES)

Lever	Modeled savings
NICU avoidance	$230,125
Tier-weighted facility steering	$128,058
Readmission reduction	$17,820
Gross modeled savings	**$376,003**

Base applies conservative targets: 15% NICU reduction, 8-point C-section reduction, 30% readmission reduction. These are deliberately more conservative than Pomelo's published outcomes; we compete on warranty and operator credibility, not on outcome claims.

Why steering is not 100% of members.

Naive models assume every member can be moved to a better facility. Real geography says otherwise. Waybright models steering through a four-tier steerability engine: full choice, quality-blind default, single-facility, and desert. Across a modeled national footprint, the tiers carry shares of roughly 55%, 24%, 18%, and 3% respectively, producing an effective steerable fraction of **85.6%** rather than 100%.

SENSITIVITY ON STEERABLE FRACTION — GROSS MODELED SAVINGS

Steerable fraction	Gross modeled savings
50% steerable	$322,745
85.6% steerable (modeled)	**$376,003**
90% steerable	$382,585

No single input is load-bearing: the case holds across the plausible range. The model is yours to interrogate; we send the live worksheet on request.

Two honest notes. The figures above are illustrative and derive from published national inputs; your own baseline replaces every one of them. And the warranty premium is funded inside the blended PEPM, evaluated as part of total cost against total modeled savings, not as a standalone insurance line.

THE OPERATOR THESIS

Built by the operator, not the optimist.

Waybright was built by an operator who serves as **Staff Vice President of Carelon Growth (Elevance Health)**, with line of sight to specialty clinical risk across oncology, MSK, maternity, and congestive heart failure, and to how a commercial book actually consumes specialty care. Every NICU admission, every C-section, every missed screening, every readmission that didn't have to happen. The thesis comes from that visibility.

Before this, fifteen years of founding, scaling, and exiting healthcare organizations: a behavioral health and addiction system that grew to thirty thousand patients across thirteen locations before it was acquired; a billing-integrity platform, ClearBill, that returned $9.2M to payers in its first six months, sold to a strategic buyer. Across the work, the organizations have served more than two hundred thousand patients. Waybright is the latest in fifteen years.

The maternity book told us what to build. The fifteen years before it told us how. Waybright is independent — no payer parent, no investor pressure to be a feature inside a bigger product, no incentive to grow before the warranty math is sound. No broker or consultant referral fee is paid or taken. We are deliberately small, deliberately measured, and deliberately accountable to the people who actually pay us.

What we'd want from a partner.

Waybright is built first for the self-funded employer segment because the warranty proves cleanest there. The category extends naturally — fully-insured commercial, Medicaid managed care, individual market — but none of those is reachable by a small founding team. They are reachable by a coalition partner with existing distribution. If that is the conversation your organization is having internally, this document is also for you.

THREE WAYS TO GET SPECIFIC

TALK

30-minute call with the founder. Direct conversation.

cal.com/joe-nalley/30min

MODEL

Send your covered lives and baseline maternity cost. We return the populated worksheet for your population.

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READ

Warranty white paper, with reserve methodology, exclusion framework, and adjudication procedure. Available on request.

The maternity book shaped the thesis, not the architecture. Waybright is independent of the care it navigates — no payer parent, no referral fees, no owned network.

REFERENCES

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