Your brokerage

RENEWAL REVIEW

Harbourline Industries — All other employees, Moncton

Benefits review · Canada Life · Policy H-500417 · Effective January 01, 2027

Harbourline Industries — All other employees, Moncton · 190 covered members · August 01, 2025 - July 31, 2026.

Prepared by Your brokerage · September 2026

Summary

A review, not a bill. Nothing here needs a signature today.

+12.1%	The ask $77,681 → $87,100 / mo · $113,028 more a year
190	Members
83%	Target loss ratio
$52,900	Pooled out claims over $25,000
7.5%	Pooling charge

In this review

1 Every class and division, side by side

On health, drugs, dental, vision and short-term disability, asked $67,493 a year more than these claims support.

	MEMBERS	PREMIUM A YEAR	ASK	LOSS RATIO TARGET 83%	ASKED VS CLAIMS
Whole plan one policy	500	$2,764,642	+12.1%	**88%**	**+$157,454**
BY CLASS · THE CARRIER APPLIES ONE INCREASE TO ALL THREE					
Owners	6	$93,863	+12.3%	not shown	—
Executives	34	$389,110	+11.8%	**107.4%**	**−$52,081**
All other employees	460	$2,281,669	+12.1%	**83.9%**	**+$225,992**
BY DIVISION · THE SAME RATES, DIFFERENT CLAIMS					
Halifax Head office	200	$1,186,437	+12%	**85.9%**	**+$74,628**
Moncton Manufacturing plant	200	$1,051,640	+12.1%	**91.7%**	**+$41,984**
St. John's Distribution	100	$526,565	+12.1%	**85.3%**	**+$40,842**

"Asked vs claims" is the carrier's ask on the experience-rated lines against what this slice's own trended claims support at the target loss ratio. A plus is money asked for that the slice's claims do not justify.

2 The reconciliation — health, drugs, dental, vision and short-term disability

Health, drugs, dental, vision and short-term disability are the lines the carrier prices at least partly on your own claims, so they are the only lines a claims argument can move. Employee Term Life, AD&D, Dependent Life, Long Term Disability and Contact are not priced on your claims. They are listed beneath

at the carrier's ask, and the two together are the whole-plan figure of $1,045,194/yr.

$901,508	the carrier's ask on health, drugs, dental, vision and short-term disability, per year — +13.3% · $75,126/mo · 86.3% of the $1,045,194 whole-plan ask
$834,015	the premium your health, drugs, dental, vision and short-term disability claims support — our independent analysis · +4.9% Built from $626,882 of claims on those lines: trended forward at the market norm for these lines (8.7% a year) over 1.42 years to the middle of the coming plan year, converted to premium at your 83% target loss ratio, then weighted line by line to your own experience against the carrier's own manual rate for each line, at the weights the carrier states (92.4% and +5.6% claims-weighted across the lines). The step from claims to premium is the carrier's admin, commissions and margin.
$67,493	above what your health, drugs, dental, vision and short-term disability claims support at the market trend — the gap to examine · 7.5% of the health, drugs, dental, vision and short-term disability ask

The carrier is asking $67,493/yr more than your health, drugs, dental, vision and short-term disability claims support at the market trend (8.7% a year), and $69,574 more than even its own 8.5% trend would justify. The pages below walk through where that gap comes from and what we do about it — nothing here is accepted as-is.

Outside the reconciliation, carried at the carrier's ask: Employee Term Life ($65,295/yr), AD&D ($9,412/yr), Dependent Life ($4,390/yr), Long Term Disability ($55,584/yr), Contact ($9,006/yr) — priced on demographics, volume or a flat fee, not on this group's claims. With that added back the letter's whole-plan ask is $1,045,194/yr (+12.1% overall).

3 What the carrier keeps

The 83% target loss ratio already gives the carrier **17% of every premium dollar** for administration, commissions and margin. What a renewal asks above that is the carrier's view of next year: its trend and, where it does not rate the group fully on its own claims, its manual rate. This is what each number would keep, against this year's claims, held flat.

ON HEALTH, DRUGS, DENTAL, VISION AND SHORT-TERM DISABILITY, PER YEAR	PREMIUM	CLAIMS	CARRIER KEEPS	SHARE
Last year, premium at today's rates	$795,411	$626,882	$168,529	21.2%
The renewal	$901,508	$626,882	$274,626	30.5%

The renewal raises the carrier's share of your health, drugs, dental, vision and short-term disability premium from 21.2% to 30.5%, 13.5 points above the carrier's own target if claims hold at last year's level; whatever next year's trend adds comes out of that. The reconciliation above grants the carrier a market trend for the whole horizon; this table grants it none. The negotiation lives between the two.

4 What's driving it — trended adjusted loss ratio

Short Term Disability	118.5%
Health	104.4%
Drug	79.4%
Dental	76.8%
Vision	70.4%

The dashed line is the 83% target — anything above it is costing you rate.

$52,900 in large claims already pooled out

The large-claim pool absorbed $52,900 this period against a $25,000 pooling level. The pooling charge is 7.5%. Confirm the pooling is doing its job. A lower level strips more of a large-claim spike off the experience-rated portion, but the pooling charge rises with it — ask the carrier to price both before moving.

One therapeutic class is 19% of drug spend

This therapy accounts for $32,675 of drug spend — 19%, concentrated in an estimated 4–11 claimants. Chronic and non-discretionary: it is a forecasting input rather than something to design out.

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One therapeutic class is 16% of drug spend

This therapy accounts for $27,516 of drug spend — 16%, concentrated in a small number of claimants. No formulary change reduces this materially — the levers are prior authorisation, a biosimilar pathway, or pooling.

One therapeutic class is 15% of drug spend

This therapy accounts for $25,796 of drug spend — 15%. Chronic and non-discretionary: it is a forecasting input rather than something to design out.

5 Where this is heading

Next year's expected claims against **today's premium**. The gap to the target is what the renewal's increase is priced to close; plan changes close it from the other side, by lowering the claims. The figure below is where it starts, before any of the changes on the following pages.

No changes, at today's premium	89%

target 83% · −$32,667 / yr in claims About $32,667 a year comes out of the experience the carrier rates before the next renewal is priced. A modelled figure, not a quote: each change at a point inside its range, stacked so no claim is counted twice. Where a change rests on an assumption it says so, and the drug figures are pending the prescription drug report. Switch off any the plan already has.

6 Getting the plan back on track

These changes are derived from **your plan's own design**, your claims, and your group's size — not a catalog. The package below is sized against the gap to target; the trims underneath are real but small, there for when you want them.

CHANGE	ESTIMATED SAVING	INCLUDED
Managed drug formulary Tiered formulary with step therapy on high-cost classes — the structural drug lever. *Assumes the plan is on an open formulary today; range pending the prescription drug report.* **In plain terms:** On an open formulary the plan pays for whichever drug is prescribed. A managed formulary is a preferred list: where several drugs do the same job, the plan covers the best-priced one first, and steps up to costlier options when the doctor confirms they're needed. The same conditions get treated — the plan just stops paying premium prices by default.	$11,136–$33,409 a year	In the total
Mandatory generic substitution One therapeutic class is 19% of drug spend. Reimburse at the generic price unless no-substitution is medically required — largely invisible to members. *Range pending the prescription drug report.* **In plain terms:** Most brand-name drugs have a chemically identical generic version at a fraction of the price. This sets the plan to pay the generic price by default. Members still get the brand when the doctor writes that substitution isn't appropriate — or by paying the small difference themselves.	$7,424–$22,273 a year	In the total

More trims — matched to this plan's design (8)

CHANGE	ESTIMATED SAVING	INCLUDED
Prior authorization on specialty drugs Guards the tail: specialty drugs are the fastest-growing part of drug spend, and one claimant can outweigh a year of ordinary prescriptions. *Assumes the plan does not already require prior authorization; at the $25,000 pooling level much of a specialty claimant's cost is paid by the pool, not the plan, so less of this reaches the plan's own claims; range pending the prescription drug report.* **In plain terms:** A handful of specialty drugs can cost more than everything else on the plan combined. Prior authorization means the carrier confirms one of those prescriptions is the right fit before it starts paying. For almost everyone this changes nothing at all, because almost nobody is on one of these drugs. A member who is prescribed one waits on an approval step, and the plan is protected from the largest single surprise a drug plan can produce.	$7,424–$29,697 a year	Not in the total
Dispensing-fee cap Steers volume to lower-fee pharmacies without cutting coverage. *Assumes the plan has no dispensing-fee cap today; range pending the prescription drug report.* **In plain terms:** Every prescription includes a pharmacy service fee on top of the drug itself, and it varies by store — a few dollars at some pharmacies, over $12 at others. A cap sets the most the plan reimburses for that fee; members using pricier pharmacies can switch, or cover the difference.	$3,712–$18,561 a year	Not in the total
Combined paramedical maximum (ceiling today: $2,500/member) Physiotherapist alone is 33% of paramedical spend; one shared cap replaces 5 per-practitioner caps. **In plain terms:** Paramedical covers massage, physiotherapy, chiropractic and similar services, each usually with its own yearly maximum. Lowering those maximums trims the heaviest users; most members never come near them.	$7,935–$19,838 a year	Not in the total
Vision $200 / 24 months → 36 months Small but clean. **In plain terms:** The vision benefit is an allowance for glasses or contacts that renews on a cycle. Raising or lowering the dollar amount changes how much a member gets toward a pair; stretching the cycle, say from every 24 months to every 36, keeps the amount intact and changes how often they can claim it. Nobody loses the benefit either way.	$3,676–$6,434 a year	Not in the total

CHANGE	ESTIMATED SAVING	INCLUDED
Introduce a $25/$50 health deductible No deductible today — first dollars are the cheapest to share. **In plain terms:** The first dollars of claims each year that a member covers before the plan starts paying — the same idea as a car insurance deductible, at a much smaller size ($25 single / $50 family). It mostly changes habits around very small claims.	$3,800–$9,500 a year	Not in the total
Dental recall 6 → 9 months Trims routine spend at the hygienist. **In plain terms:** A recall is the routine cleaning and check-up. Many offices book every 6 months out of habit; for most healthy adults, 9 months is clinically ordinary. This changes how often the plan pays for routine visits — anything a dentist flags as needed is still covered.	$7,455–$16,773 a year	Not in the total
Hold to the prior-year dental fee guide Trims fee inflation; usually invisible to members. *Assumes the plan reimburses at the current-year fee guide.* **In plain terms:** Each province's dental association publishes a fee guide every year, and prices creep up with it. Holding reimbursement to the prior year's guide means the plan does not automatically absorb this year's increase. Most dentists bill at the current guide, so a member may see a small balance — typically a few dollars a visit — where the plan once covered the whole amount.	$3,727–$11,182 a year	Not in the total
Dental annual maximum $1,500 → $1,000 Affects only heavy dental years — most members never reach the cap. **In plain terms:** The most the plan will pay for dental work per person per year. Lowering it touches only the heaviest dental years — most members never come near the ceiling.	$3,727–$11,182 a year	Not in the total

Not proposed for this plan: Health coinsurance step to 90% — already at 80% — this step does not exist on your plan; Health coinsurance step to 80% — already at 80% — no further cost-share step worth taking.

What we still need from you

- **The prescription drug report** — a Top DIN listing or the carrier's drug claims report. It turns the drug ranges above into analysis of this plan's own prescriptions.

None of these decisions are due today. We run the carrier, the paperwork, and the staff communications end to end.

7 The renewal, line by line

Every benefit, what you pay today against the renewal. The renewal column is the carrier's ask as this report states it. Nothing in it has been negotiated yet.

BENEFIT	LIVES / VOL.	CURRENT / MO	RENEWAL / MO	CHANGE
POOLED BENEFITS				
Employee Term Life	24,510,000	$5,245	$5,441	+3.7%
AD&D	24,510,000	$784	$784	+0%
Dependent Life	118	$366	$366	+0%
Long Term Disability	681,174	$4,251	$4,632	+9%
Short Term Disability	157,194	$9,039	$10,123	+12%
Contact	190	$751	$751	+0%
Pooled benefits subtotal		**$20,435**	**$22,097**	**+8.1%**
HEALTHCARE				
Single	72	$2,693	$3,110	+15.5%
Couple	46	$3,441	$3,974	+15.5%
Family	72	$7,001	$8,086	+15.5%
Healthcare subtotal		**$13,135**	**$15,171**	**+15.5%**
DRUGS				
Single	72	$4,450	$5,206	+17%
Couple	46	$5,686	$6,652	+17%
Family	72	$11,569	$13,536	+17%
Drugs subtotal		**$21,704**	**$25,394**	**+17%**
DENTAL				
Single	72	$4,147	$4,541	+9.5%
Couple	46	$5,299	$5,802	+9.5%
Family	72	$10,783	$11,807	+9.5%

BENEFIT	LIVES / VOL.	CURRENT / MO	RENEWAL / MO	CHANGE
Dental subtotal		**$20,229**	**$22,151**	**+9.5%**
VISION				
Single	72	$446	$469	+5%
Couple	46	$570	$599	+5%
Family	72	$1,161	$1,219	+5%
Vision subtotal		**$2,177**	**$2,287**	**+5%**
Total		**$77,681**	**$87,100**	**+12.1%**

The experience behind it

The carrier's trended loss ratio by benefit — the claims figure its own working rates on, carried forward to next year, against premium. Anything over the 83% target is running above what it's priced for. Credibility is how much of your own result the carrier uses.

BENEFIT	TRENDED LOSS RATIO	CREDIBILITY
Short Term Disability	118.5%	60%
Health	104.4%	100%
Drug	79.4%	100%
Dental	76.8%	100%
Vision	70.4%	100%

8 The road ahead, with your selections

Every saving above has an operational half — what actually changes for your staff. This list follows the switches: flip a change off and its consequences leave with it.

- **Managed drug formulary**
  New prescriptions in managed classes start on the preferred option; moving off it needs the prescriber's supporting note. Existing therapies usually carry over — we confirm the carrier's grandfathering in writing before anything changes.
- **Mandatory generic substitution**
  Pharmacists fill the generic unless the prescriber writes no-substitution; a member who insists on the brand pays the difference at the counter.

Every change is communicated to staff before it takes effect — we draft the notice, file the carrier amendment, and take the questions.

9 The cushion already in place

Claims above **$25,000 a year (per person, per family, or per employee and separately for dependents, as the contract sets it)** are pooled across the carrier's whole book, not carried by your plan alone. This period about **$52,900** was absorbed by that pooling — the figures above are already net of it.

10 What happens next

ACTION	WHEN
We check the carrier's math on this renewal letter The letter is in hand and this review is our line-by-line check of it — the pooling, the trend factor, the credibility. Anything that does not reconcile is the first thing we take back to the carrier.	Done: this review
We negotiate before anything is accepted The trend factor and the credibility behind the increase are negotiated, not fixed. If the number stays high, phasing it across the year is on the table.	Upcoming — at the renewal letter (expected about Oct 18, 2026)
Turn on regular experience monitoring Get experience on the tightest cadence the carrier will produce, quarterly where it offers it, so a benefit crossing a threshold is caught while the window is still open and there's time to act, not reconstructed at renewal when it's already locked.	Now
Implement amendments + member communication Roll out the agreed plan-design changes and brief members on what changed and why, especially any new or lower maximum. Clear communication means members hear the why before they reach it — it protects trust; it doesn't make a lower maximum not a takeaway.	Upcoming — at renewal (Jan 1, 2027)