Your brokerage

RENEWAL REVIEW

Harbourline Industries — Executives, Halifax

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

20 covered members · September 01, 2025 - August 31, 2026.

Prepared by Your brokerage · November 2026

Summary

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

This reviews the renewal taking effect 1 February 2027, which has not started yet. The figures below are the incoming year's.

+11.7%	The ask $19,170 → $21,417 / mo · $26,965 more a year
20	Members
83%	Target loss ratio
$41,200	Pooled out pooling level $25,000
7.5%	Pooling charge

In this review

1. Every class and division, side by side
2. The reconciliation — health, drugs, dental, vision and short-term disability
3. Where the renewal should land
4. What the carrier keeps
5. What's driving it — trended adjusted loss ratio
6. Where this is heading
7. Getting the plan back on track
8. The renewal, line by line
9. The road ahead, with your selections
10. The cushion already in place
11. What happens next

1 Every class and division, side by side

On health, drugs, dental, vision and short-term disability, asked $24,693 a year less 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

The carrier is asking $24,693/yr less than your health, drugs, dental, vision and short-term disability claims support even at our assumed market trend (≈ 9.5% a year). That is not a saving: it is a shortfall the carrier is carrying into next year, and the following renewal will look to recover it. The pages below are about getting ahead of that — the plan changes you make now are what shape the number you see then.

The carrier's ask on health, drugs, dental, vision and short-term disability, per year, against what the same claims support. These are the lines priced at least partly on your own claims, so the only ones a claims argument can move. That is 81.1% of the $257,005 whole-plan ask.



How we got $233,060, what your health, drugs, dental, vision and short-term disability claims support

1. Start from $168,003 of claims on those lines, already at today's exposure by Canada Life's adjusted premium at today's rates.
2. Trend forward at our assumed market trend for these lines (≈ 9.5% a year, our assumption, not a figure from the letter) over 1.42 years to the middle of the coming plan year.
3. Convert to premium at your 83% target loss ratio. The step from claims to premium is the carrier's admin, commissions and margin.
4. Weight each line on the credibility the carrier states for it: 97.4% on your own experience across the lines, blended by claims, and the rest on the carrier's own manual rate for each line, which across the lines sits a claims-weighted +5.9% from what you pay today.
5. **$233,060** a year is the premium these claims support (+26.9% on today's).

Outside the reconciliation, carried at the carrier's ask: Employee Term Life ($27,492/yr), AD&D ($3,963/yr), Dependent Life ($632/yr), Long Term Disability ($15,603/yr), Contact ($948/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 $257,005/yr (+11.7% overall).

3 Where the renewal should land

The ask is at or below what the health, drugs, dental, vision and short-term disability claims support, so an appeal has nothing to win on the claims. The plan changes are what move it. Each figure is shown as asked and with the plan changes switched on in this review; the changes come out of the claims the

carrier rates, at the same loss ratio, and the pooled lines carry across at the ask.

	PER MONTH	PER YEAR	VS TODAY
What you pay today	$19,170	$230,039	—
The carrier's ask as written	$21,417	$257,005	+11.7%
The ask, with your plan changes	$17,817	$213,808	−7.1%
What the claims support the ask is already under it	$23,475	$281,698	+22.5%
Claims support, with your plan changes	$19,448	$233,382	+1.5%

4 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	$183,677	$168,003	$15,674	8.5%
The renewal	$208,367	$168,003	$40,364	19.4%

The renewal raises the carrier's share of your health, drugs, dental, vision and short-term disability premium from 8.5% to 19.4%, 2.4 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 our assumed market trend for the whole horizon; this table grants it none. The negotiation lives between the two.

5 What's driving it — trended adjusted loss ratio

Short Term Disability	57.2%
Health	114.7%
Drug	123%
Dental	93.3%
Vision	93.8%

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

Short Term Disability ran well under target: ask for a decrease

Short Term Disability ran at 57.2% of premium this period, against the 83% target, yet its rate goes up 12%. Ask the carrier for a decrease on short term disability on its own.

One therapeutic class is 19% of drug spend

This therapy accounts for $9,966 of drug spend — 19%, concentrated in an estimated 1–4 claimants. Chronic and non-discretionary: it is a forecasting input rather than something to design out.

One therapeutic class is 18% of drug spend

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One therapeutic class is 16% of drug spend

This therapy accounts for $8,392 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.

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$41,200 in large claims already pooled out

The large-claim pool absorbed $41,200 this period: the part of claims above the $25,000 level. The pooling charge is 7.5%. Ask the carrier whether that claim is still running: up to $25,000 a year of a continuing large claim stays in the experience-rated portion. A lower level strips more of a large-claim spike off it, but the pooling charge rises with it — ask the carrier to price both before moving.

6 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	103.9%

target 83% · −$34,829 / yr in claims About $34,829 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. Any the plan already has should come out of the total.

7 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
Health coinsurance 100% → 80% The deep step — highest member impact, held for when the gap demands it. **In plain terms:** Coinsurance is the split between the plan and the member. At 80% a member pays 20 cents on each dollar — the deepest cost-share step, reserved for when a plan genuinely needs pulling back from the edge.	$22,583–$25,093 a year	In the total
Combined paramedical maximum (ceiling today: $5,000/member) Psychologist/Social Worker alone is 31% 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.	$3,011–$7,527 a year	In the total

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.	$1,892–$5,675 a year	In the total
Vision $400 / 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.	$1,619–$2,833 a year	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.	$631–$3,153 a year	In the total

More trims — matched to this plan's design (7)

CHANGE	ESTIMATED SAVING	INCLUDED
Health coinsurance 100% → 90% Health is running 118.7%; a 10% member share changes claiming behaviour across every health dollar. **In plain terms:** Coinsurance is the split between the plan and the member. At 100% the plan pays every dollar; at 90% a member pays 10 cents on each dollar claimed. That small share makes everyone slightly price-aware — which is exactly what a carrier looks at when it sets next year's rates.	$11,292–$12,546 a year	Not in the total

CHANGE	ESTIMATED SAVING	INCLUDED
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.	$1,261–$3,783 a year	Not in the total
Prior authorization on specialty drugs Guards the tail: specialty classes are where a small group's drug line blows out. *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.	$1,261–$5,045 a year	Not in the total
Dental recall 6 → 9 months Trims routine spend at the hygienist. *Assumes routine exams and cleanings are 30–40% of dental claims, an assumed typical mix rather than this plan's own by type of service.* **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.	$4,541–$6,055 a year	Not in the total

CHANGE	ESTIMATED SAVING	INCLUDED
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.	$1,362–$2,271 a year	Not in the total
Dental annual maximum $2,500 → $2,000 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.	$908–$2,725 a year	Not in the total
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.	$400–$1,000 a year	Not in the total

Changes that reach the same claims are never both on by default, and switched on together each counts only on the claims the other leaves, so no saving is counted twice.

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.

8 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	10,320,000	$2,208	$2,291	+3.7%
AD&D	10,320,000	$330	$330	+0%
Dependent Life	17	$53	$53	+0%
Long Term Disability	191,207	$1,193	$1,300	+9%
Contact	20	$79	$79	+0%
Pooled benefits subtotal		**$3,864**	**$4,053**	**+4.9%**
EXPERIENCE-RATED BENEFITS				
Short Term Disability	30,000	$1,725	$1,932	+12%
HEALTHCARE				
Single	3	$312	$360	+15.5%
Couple	6	$1,248	$1,441	+15.5%
Family	11	$2,974	$3,435	+15.5%
Healthcare subtotal		**$4,534**	**$5,237**	**+15.5%**
DRUGS				
Single	3	$294	$344	+17%
Couple	6	$1,176	$1,376	+17%
Family	11	$2,803	$3,279	+17%
Drugs subtotal		**$4,273**	**$4,999**	**+17%**
DENTAL				
Single	3	$279	$306	+9.5%
Couple	6	$1,116	$1,222	+9.5%
Family	11	$2,660	$2,912	+9.5%
Dental subtotal		**$4,055**	**$4,440**	**+9.5%**
VISION				
Single	3	$50	$52	+5%

BENEFIT	LIVES / VOL.	CURRENT / MO	RENEWAL / MO	CHANGE
Couple	6	$198	$208	+5%
Family	11	$472	$496	+5%
Vision subtotal		**$719**	**$755**	**+5%**
Total		**$19,170**	**$21,417**	**+11.7%**

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	57.2%	60%
Health	114.7%	100%
Drug	123%	100%
Dental	93.3%	100%
Vision	93.8%	100%

Life non-evidence maximum: $400,000 in force, $600,000 available — members above $400,000 need medical evidence; ask whether the higher NEM applies.

9 The road ahead, with your selections

Every saving above has an operational half — what actually changes for your staff.

- **Health coinsurance 100% → 80%**
  Members pay 20% of health and drug costs — the deepest cost-share step, and the one to communicate most carefully. We run an all-hands note and a Q&A.
- **Combined paramedical maximum (ceiling today: $5,000/member)**
  One shared annual maximum replaces the per-practitioner caps — members who lean on one therapy will reach it sooner; most members never touch 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.

- **Vision $400 / 24 months → 36 months**
  Frames and lenses stretch to the longer cycle; members mid-cycle keep their current entitlement.
- **Dispensing-fee cap**
  Members at higher-fee pharmacies pay the difference or switch — we provide a list of low-fee pharmacies nearby.

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

10 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 **$41,200** was absorbed by that pooling — the figures above are already net of it.

11 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.	Now: the letter is in hand
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 (Feb 1, 2027)

Self-insured health is not generally offered at this size, so no self-insured budget is drawn here.

(assumed: carriers seldom offer self-insured health below 25 people on health; 20 are enrolled here)