
REPORT OF THE

# Auditor General of New Brunswick

## Performance Audit

Volume II

2026

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AUDITOR GENERAL OF NEW BRUNSWICK | VÉRIFICATEUR GÉNÉRAL DU NOUVEAU-BRUNSWICK

Speaker of the Legislative Assembly
Province of New Brunswick

Madam,

As required under section 15(1) of the *Auditor General Act,* I am submitting Volume II of my Office's 2026 Report to the Legislative Assembly.

Respectfully submitted,

Paul Martin, FCPA, FCA
Auditor General

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September 2026

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**REPORT OF THE**

# Auditor General of New Brunswick

**VOLUME II 2026: PERFORMANCE AUDIT**

CHAPTER 1:

# Auditor General's Comments

Our 2026 Volume II report includes two reports:

- Collaborative Care Clinic Expansion – Department of Health
- Rate Rider Surcharge – NB Power

## Collaborative Care Clinic Expansion

Between April 2025 and March 2026, the Department of Health announced 14 collaborative care clinics as part of its primary care reform. We found the Department did not have adequate information to demonstrate clinics were improving access to primary care where it was needed most. Clinic expansion was not guided by a documented provincial assessment of community need. Full costs and long-term affordability were not assessed, and performance targets and monitoring were inconsistent. Patient attachment and waitlist reductions could not be reliably demonstrated because key data and public reporting were incomplete or inaccurate. Recommendations have been made to strengthen needs-based planning, financial analysis, performance monitoring, data quality and accountability.

## Rate Rider Surcharge

As of March 31, 2026, variance account balances to be recovered from customers through the rate rider surcharge have grown to $384 million. NB Power's regulatory variance accounts are used to defer differences between forecasted and actual electricity sales and supply costs. Since 2022, the recovery period has expanded from two to eight years and additions have outpaced recoveries in two of three years, resulting in more costs being deferred to future ratepayers. The long-term sustainability of the framework depends on improved operating performance and limiting further growth in deferred balances.

## Recognition

We would like to recognize departmental and Crown corporation staff for their assistance as we completed our work for this report. I also want to thank my team for their dedication and professionalism in fulfilling the mandate of the Office of the Auditor General of New Brunswick.

**Paul Martin**, FCPA, FCA
Auditor General

DEPARTMENT OF HEALTH

2026

# Collaborative Care Clinic Expansion

**Chapter 2**

**Volume II: Performance Audit**
Independent Assurance Report

AUDITOR GENERAL OF NEW BRUNSWICK
VÉRIFICATEUR GÉNÉRAL DU NOUVEAU-BRUNSWICK

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# Department of Health

## COLLABORATIVE CARE CLINIC EXPANSION


# Chapter 2 Highlights

| | | |
|---|---|---|
| No plan to address unmet needs | Full costs and long-term affordability were not assessed | Performance targets and monitoring were inconsistent |
| Patient attachment and waitlist reductions could not be reliably demonstrated | Waitlist and public reporting were incomplete or inaccurate | |

**OVERALL CONCLUSION:**

The Department of Health did not have adequate information to demonstrate that collaborative care clinics were improving access to primary care where it was needed most. Gaps in cost analysis, performance monitoring and patient attachment data also limited the Department's ability to assess results, address unmet needs and demonstrate value for money.

# Results at a Glance

## COLLABORATIVE CARE CLINIC EXPANSION

## Model expanded without reliable information

| FINDINGS | |
|---|---|
|  | Clinic expansion was **not guided** by documented community need or a plan for remaining gaps |
|  | Full costs and long-term affordability were **not assessed** |
|  | Monitoring **did not** provide complete, reliable or timely information |
|  | Performance targets were **not applied** consistently |
|  | **Lack** of intervention thresholds |
|  | Waitlist reductions and newly attached patients **could not** be reliably demonstrated |

# About the Audit

## INTRODUCTION TO THE AUDIT

**2.1** The *Regional Health Authorities Act* outlines the delivery and administration of health services, stating that the Minister of Health is responsible for the strategic direction of the health care system and may:

- establish goals, objectives and standards for the provision of health services in the Province or areas of the Province
- establish performance measures and targets to promote the effective and efficient utilization of health services
- conduct financial, human resources and information technology planning for the health care system

**2.2** Collaborative care clinics in New Brunswick are team-based primary care practices where family physicians, nurses and other health professionals work together to provide coordinated, ongoing care to an enrolled group of patients. The model is intended to improve access, continuity of care and the efficient use of each professional's expertise.

**2.3** Government has committed to establishing 30 collaborative care clinics over four years beginning April 1, 2025. During the period from April 1, 2025 to March 31, 2026, the Department of Health announced 14 collaborative care clinics across the Province.

## WHY WE CHOSE THIS TOPIC

**2.4** The implementation and expansion of collaborative care clinics represent a significant change in how primary health care is organized and delivered in New Brunswick. The initiative involves substantial public resources and is intended to address persistent challenges in access to primary care.

**2.5** An audit at this stage is timely because many clinics are newly established or still being developed. Early examination can identify weaknesses in planning, governance and performance measurement before the model is fully implemented and further resources are committed.

## AUDITEE

**2.6** Our auditee was the Department of Health (the Department). We also made enquiries and obtained audit evidence from the two regional health authorities (RHAs).

## AUDIT SCOPE

**2.7** For the purposes of our audit, our scope included the 14 collaborative care clinics that were announced during our audit period, April 1, 2025 – March 31, 2026. Information outside of this period was also collected and examined as deemed necessary. As part of our work, we reviewed relevant legislation, physician agreements, policy, annual reports, and data sets. We also interviewed various staff from the Department.

**2.8** More detail on the audit objective, criteria, scope and approach we used in completing our audit can be found in Appendix II and Appendix III.

## AUDIT OBJECTIVE

**2.9** Our audit objective was to determine if the Department of Health's expansion of collaborative care clinics in New Brunswick was planned, implemented, and monitored to increase access to primary care where it is needed most.

## CONCLUSION

**2.10** The Department did not have adequate information to demonstrate that collaborative care clinics were improving access to primary care where it was needed most. Gaps in cost analysis, performance monitoring and *patient attachment[1] data also limited the Department's ability to assess results, address unmet needs and demonstrate value for money.

1 ***Patient attachment*** means the formal association of a patient with a primary care provider or collaborative care clinic that has accepted responsibility for providing and coordinating the patient's ongoing primary health care.

# Background

**2.11** Primary health care is generally the first point of contact with the health system and includes prevention, diagnosis, treatment, chronic disease management and coordination with other services. Effective primary care can improve health outcomes and reduce avoidable reliance on emergency departments and hospitals.

**2.12** Having a family doctor or nurse practitioner is important, however, attachment does not necessarily ensure timely access. New Brunswick Health Council reporting indicated that 73% of survey respondents had a family doctor or nurse practitioner in 2025, while only 34% reported being able to access a provider within five days.

**2.13** Under the previous physician model, physicians generally operated independently and were compensated primarily through salary or fee-for-service arrangements. The collaborative care clinic model brings physicians and other health professionals together in team-based clinics, with funding and service agreements intended to support coordinated care, larger patient panels and improved access to primary care.

**2.14** The Province has made collaborative, team-based care a central part of primary care reform. The 2025–2029 Physician Services Agreement, as signed by the Minister of Health in March 2026, establishes collaborative care clinics as a central component of New Brunswick's primary care strategy. In 2025-26, the Department's expenditure on collaborative care clinics was $34.2 million. The amount excludes fee-for-service expenditures and approved funding for one-time and infrastructure costs.

**2.15** The Department informed us that the locations of the first seven collaborative care clinics were based on government's announced commitments and that the RHAs submitted locations for the next seven collaborative care clinics. Funding was provided by the Department.

**2.16** The locations of the clinics are as follows:

| Previously Announced Government Commitments (First Seven) | Clinics Recommended by RHAs (Second Seven) |
|---|---|
| Fredericton (Zone 3) | Edmundston (Zone 4) |
| Lamèque (Zone 6) | St. Stephen (Zone 2) |
| Tantramar (Zone 1) | Bathurst (Zone 6) |
| Carleton North (Zone 3) | Saint John North (Zone 2) |
| Miramichi (Zone 7) | Eastern Charlotte (Zone 2) |
| Campbellton (Zone 5) | Nackawic-Millville (Zone 3) |
| Moncton (Zone 1) | St. Andrews (Zone 2) |

*Source: Prepared by AGNB based on information from the Department*

# No Provincial Plan to Address Unmet Needs Where Physicians Do Not Voluntarily Adopt the Model

**2.17** The Physician Services Agreement allows eligible physicians to choose whether to participate in the collaborative care clinic model and does not require clinics to be established in communities selected by the Department based on relative need. As a result, the Department does not have full control over where clinics are established.

**2.18** However, the Department remains responsible for planning and implementing the model, funding clinic arrangements, allocating supporting resources, and assessing whether the model is improving access to primary care across the province. We expected the Department to use documented community health needs and access gaps to inform these decisions and to identify how unmet needs would be addressed in communities where physicians did not voluntarily adopt the model.

**2.19** We found that the Department had not documented how relative community need informed the implementation, funding, sequencing or resourcing of collaborative care clinics. The Department had not established a provincial plan to address areas of high need that may not benefit from the voluntary expansion of the model.

**Recommendation**

**2.20** We recommend that the Department of Health develop and implement a provincial plan that uses documented community health needs and access gaps to guide the implementation, funding and resourcing of collaborative care clinics and identifies how unmet needs will be addressed in areas where physicians do not voluntarily adopt the model.

# Collaborative Care Model Was Implemented Without Comprehensive Financial Analysis

**2.21** The new Physician Services Agreement provides enhanced physician compensation and substantial operational support, including funding for administrative and nursing staff, *allied health services[2] and clinic overhead for collaborative care clinics. In return, participating clinics are expected to add additional patients (primarily from the provincial waitlist), improve access to appointments, deliver comprehensive primary care and report regularly against established performance measures.

**2.22** The table below shows the maximum annual incremental cost per physician (over and above the physician solo practice model).

| Maximum Annual Incremental Eligible Expenses per Physician | |
|---|---|
| **Expense Category** | **Annual Amount** |
| Interdisciplinary care coordination fee | $45,000 |
| Physician overhead | $68,994 |
| Medical office assistants | $188,127 |
| Licensed practical nurses/registered nurses | $313,385 |
| Allied health services | $125,000 |
| *Capitation[3] | $54,000 |
| **Total** | **$794,506** |

*Source: Prepared by AGNB based on information from the Department*

**2.23** These amounts exclude one-time, infrastructure and regular salary or fee-for-service costs.

2 ***Allied health services** can include social workers, licensed counseling therapists, registered dietitians, physiotherapists, occupational therapists, respiratory therapists, pharmacists, advanced/community paramedics, patient navigators.

3 ***Capitation** is a funding model under which a physician, clinic or health-care organization receives a fixed payment for each enrolled or attached patient over a specified period, regardless of how many services that patient uses (came into effect April 1, 2026).

2.24 The Physician Services Agreement establishes funding and service requirements for an initial four-year period. However, the Department has not assessed the long-term service needs, costs or sustainability of the collaborative care model beyond that period.

2.25 We requested that the Department provide the costing that was completed to support the cost of the collaborative care clinic initiative and we noted the following:

- projected costs only included physician salary, benefits and capitation
- projections did not include the following costs that clinics are eligible for under the Physician Services Agreement and common offer:
    - physician overhead
    - medical office assistants
    - licensed practical nurses/registered nurses
    - allied health services
    - electronic medical record system costs
- projections were developed using an average of 1,100 patients per physician rather than the minimum targeted number of 1,400 patients
- there was no sensitivity analysis completed for different *panel sizes[4] (supports available vary with patient numbers)

2.26 Without thorough analysis, government cannot fully assess the model's affordability, value for money, long-term sustainability, or make informed decisions about its renewal or expansion.

### Recommendation

2.27 We recommend that the Department of Health complete and regularly update a comprehensive financial analysis of the collaborative care model covering both the current four-year agreement term and the period beyond it. The analysis should include operational support, infrastructure and implementation costs, and assess the financial impact of different patient panel sizes and physician participation rates.

4 ***Panel size** is the number of patients formally attached to a physician or primary careteam for ongoing care.

# Inconsistent Target Setting Practices

**2.28** Effective implementation requires clearly defined objectives, baselines, performance indicators and targets. Measures should allow the Department to determine whether they are improving access, equity, quality, productivity and patient outcomes.

**2.29** Public communications have reported:

- the number of clinics established
- the numbers of newly attached patients
- anticipated waitlist reductions

**2.30** These are relevant measures of activity and attachment, but attachment alone does not demonstrate that patients are receiving timely, continuous or comprehensive care. The Province's own action plan recognizes that high attachment rates have historically coexisted with difficulties obtaining appointments and limited after-hours access.

**2.31** The following key performance indicators and related targets were established by the Department:

| Performance Indicators | Target |
|---|---|
| Number of visits per physician per year | 3,680 |
| Number of patients per physician | 1,400 |
| Number of days for third next available appointment | 5 days |

*Source: Prepared by AGNB based on information from the Department*

**2.32** The Department informed us that established targets are documented in either accountability agreements (for fee-for-service physicians) or employment contracts (for salaried physicians).

**2.33** We reviewed six accountability agreements for fee-for-service physicians and noted that none contained all three targets.

**2.34** We reviewed two employment contracts for salaried physicians and noted:

- 1 had a target of only 1,004 patients per full-time-equivalent (FTE)
- 1 had a target of 1,120 for 0.9 of an FTE (which equates to 1,244 patients per 1.0 FTE)
- neither had a target for total number of visits per year

**2.35** Departmental staff informed us they were aware of regional disparities as they relate to target setting and could not provide us with documentation pertaining to the rationale for the differences.

### Recommendation

**2.36** We recommend that the Department of Health ensure consistent application of established performance targets to all collaborative care physicians. Any approved variation should be supported by documented criteria and rationale.

# Public Reporting Did Not Accurately Measure Newly Attached Patients

**2.37** The Department uses data submitted by the RHAs to prepare monthly reports on collaborative care clinic performance. These reports are also used to support public announcements about the model's progress.

**2.38** On April 29, 2026, the Government of New Brunswick reported that the 14 announced collaborative care clinics had attached 6,853 additional patients and were expected to attach 22,204 patients in total by 2028.

**2.39** We reviewed the Department's April 22, 2026 progress report supporting this announcement and found:

- reporting inaccuracies in six of the 14 clinic reports, including:
  - arithmetic errors
  - incorrect values used in calculations
- negative additional-patient numbers (reductions) at six clinics, ranging from nine to 261 fewer patients
- 12 of the 14 clinics were identified as being on track, despite the fact that targets related to key performance indicators had not been met

**2.40** The Department informed us that it generally considered factors such as staffing and infrastructure when assessing clinic progress. However, it had not established formal requirements or measurable criteria for making this assessment.

**2.41** The methodology the Department uses to calculate and report numbers of newly attached patients is as follows:

*Total patient count - Baseline count = Newly attached patients*

**2.42** The baseline represented the patients already attached to participating physicians before they entered the collaborative care model.

**2.43** The Department calculated the reported increase of 6,853 patients by subtracting each clinic's baseline patient count from its current patient count.

**2.44** This calculation measures the net change in the number of patients recorded at a clinic. It does not necessarily measure how many newly attached patients received a primary care provider through the model.

**2.45** The hypothetical example below shows why the Department's current methodology for calculating newly attached patients is not accurate:

| Calculation component | Number of patients |
|---|---|
| Baseline patient count | 5,000 |
| Current patient count | 5,300 |
| **Reported newly attached** | **300** |

*Source: Hypothetical example prepared by AGNB for illustrative purposes*

**2.46** However, the 300-patient increase could be made up of several changes:

| Change in recorded patient count | Impact |
|---|---|
| Newly attached patients | +150 |
| Patients added through data adjustments (e.g. erroneous previous omission, new physician, electronic medical record implementation) | +200 |
| Patients removed due to death | -50 |
| **Net change in recorded patient count** | **+300** |

*Source: Hypothetical example prepared by AGNB for illustrative purposes*

**2.47** In this example, the Department would have reported 300 newly attached patients, even though there were only 150.

**2.48** Without a reliable method to identify and verify newly attached patients, the Department cannot accurately assess or publicly report the model's impact on patient attachment.

### Recommendations

**2.49** We recommend that the Department of Health establish and apply a documented methodology to accurately identify, validate and report the number of patients newly attached through collaborative care clinics.

**2.50** We recommend that the Department of Health establish clear criteria for assessing whether clinics are on track and verify accuracy of performance data.

# Performance Monitoring Requires Improvement

**2.51** We understand that clinics are generally provided 12 to 24 months to achieve their stated targets and that most clinics have not yet been operating for that length of time. Accordingly, it would not be reasonable to expect all targets to be fully achieved during the early stages of implementation.

**2.52** However, the Department should be regularly monitoring each clinic's progress against established milestones and expected trajectories.

**2.53** Timely monitoring would allow the Department to identify clinics that are falling behind, understand the reasons for delays and intervene early with appropriate corrective action or support, rather than waiting until the end of the implementation period to determine whether targets have been missed.

**2.54** The Department obtains monthly reporting that shows progress against some target data from the RHAs. Some of that performance information is used by the Department to produce its monthly Primary Health Care CCC Progress Update report.

## UNABLE TO DETERMINE THE NUMBER OF VISITS PER PHYSICIAN

**2.55** One of the key performance targets for collaborative care clinics is an annual target of 3,680 patient visits per physician. However, we determined:

- reporting from Horizon is at the clinic not physician level
- reporting from Vitalité does not include actual numbers of patient visits

**2.56** The Department does not include performance information on this target in its monthly performance reporting.

### Recommendation

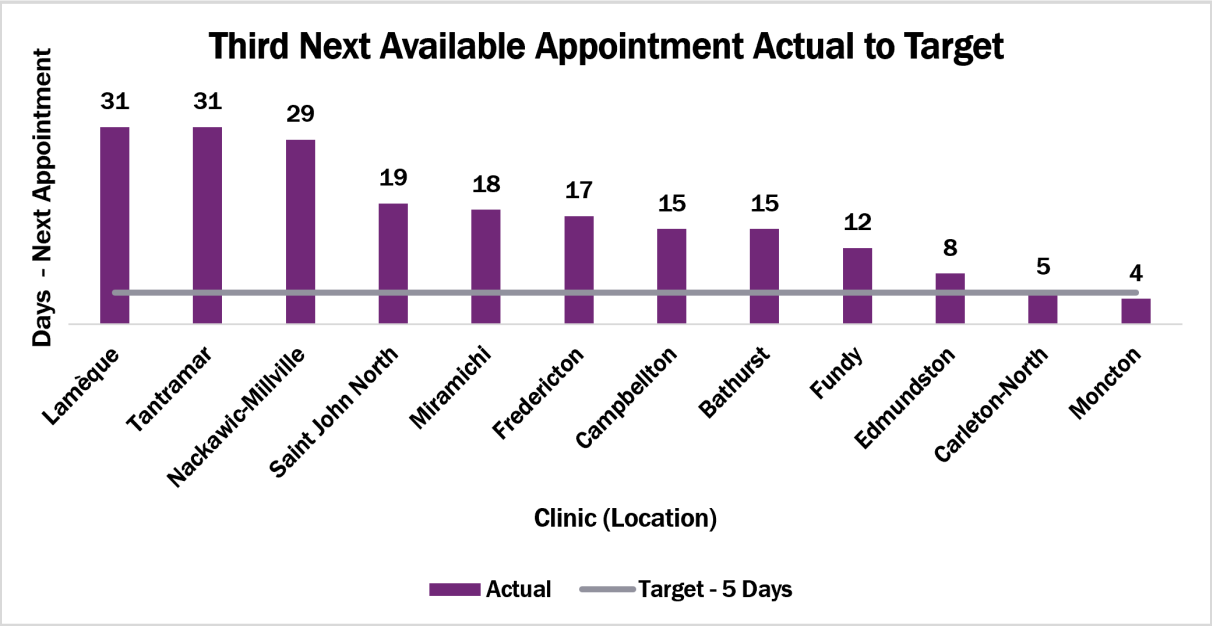
**2.57** We recommend that the Department of Health require the Regional Health Authorities to report complete and reliable visit data by physician. The Department should regularly compare actual results with established targets.

## THIRD NEXT AVAILABLE APPOINTMENT TARGET NOT MET

**2.58** Another key performance indicator for collaborative care clinics is third next available appointment. The College of Family Physicians of Canada identifies this as a key measure of primary care access. It represents the average number of days between a patient's request for an appointment and the third next available regular appointment with a primary care provider.

**2.59** The third next available appointment is used because the first or second opening may result from a recent cancellation or another unusual gap in the schedule. Using the third available appointment provides a more reliable indication of how long patients generally wait for a regular appointment.

**2.60** The Department has established the target for the third next available appointment as five days. For collaborative care clinics that were opened during our audit period, only two of the 12 met the target as noted below:




*Source: Prepared by AGNB based on April 22, 2026 Primary Health Care CCC Progress Update*

**2.61** While clinics may require time to achieve their performance targets during the early stages of implementation, the Department should establish interim milestones and expected performance trajectories to assess whether each clinic is progressing as planned. The Department should also define intervention thresholds that identify when performance requires further review, an improvement plan, additional support or other corrective action.

## Recommendation

**2.62** We recommend that the Department of Health strengthen its monitoring of collaborative care clinics by:

- establishing interim milestones and expected performance trajectories for each clinic
- obtaining complete and reliable performance information, including patient visits by physician
- defining thresholds that trigger further review, improvement plans or corrective action
- regularly assessing clinic results against established targets and taking timely action where performance is below expectations

# Reliable Waitlist Data and a Plan to Address Remaining Need Were Not Established

**2.63** The Department acknowledged that the New Brunswick Health Link waitlist relies on individuals to self-register and, therefore, does not provide a complete or reliable measure of the number of New Brunswick residents without a primary care provider. As of June 10, 2026, Health Link reported 126,576 individuals on the waitlist.

**2.64** To develop a more complete estimate, the Department compared the number of individuals with active Medicare cards with its records of patients assigned to a primary care provider. Although the analysis remained in draft at the time of our audit, it estimated that approximately 271,703 New Brunswickers did not have a primary care physician, more than twice the number reported through Health Link.

**2.65** We requested the data supporting this analysis and found that it did not identify the location of unattached residents by health zone or area of the Province.

**2.66** The draft analysis also indicated that the scale of unmet need could exceed the additional patient capacity expected from the collaborative care model. The Department's planning assumed that 45% of physicians would participate in the model. Even if anticipated participation and the patient-panel target of 1,400 were achieved, the model alone was not expected to attach all residents identified through the Department's analysis.

**2.67** The Department had not documented the extent of the projected remaining capacity gap or how it would be addressed through other primary care initiatives.

2.68 Without accurate information on the number and geographic distribution of unattached residents, and a clear understanding of how much of that need can be addressed through collaborative care clinics, the Department cannot effectively assess demand, allocate resources, establish attachment targets or plan for remaining unmet primary care needs.

**Recommendation**

2.69 We recommend that the Department of Health:

- finalize and implement a reliable process to identify and regularly report the number and geographic distribution of New Brunswick residents without a primary care provider
- assess the collaborative care model's expected contribution to reducing the number of unattached residents
- identify how remaining unmet primary care needs will be addressed through other initiatives and resources

# Department Not Monitoring if New Patients Came off the Waitlist

**2.70** The Physician Services Agreement states that physicians are expected to take additional patients primarily from the official provincial waitlist.

**2.71** Government announcements also linked the collaborative care clinic model to reducing the waitlist. On December 8, 2025, government reported that 10 clinics confirmed in 2025 were expected to remove more than 14,000 people from the primary care waitlist. On March 23, 2026, government reported that the St. Andrews clinic was expected to attach all 603 people on its local waitlist within six to 12 months.

**2.72** Despite these expectations, the Department was not analyzing newly attached patients to determine whether they had previously been on the provincial waitlist. As part of our audit, we attempted to determine how many newly attached patients had come from the waitlist; however, the Department was unable to provide the data needed to complete this analysis.

**2.73** Without this information, the Department cannot determine whether collaborative care clinics are meeting the expectation to prioritize patients from the provincial waitlist or accurately assess the model's impact on reducing the number of people waiting for a primary care provider.

**Recommendation**

**2.74** We recommend that the Department of Health track and verify whether patients newly attached through collaborative care clinics were previously on the provincial waitlist and use this information to assess and report the model's impact on reducing the waitlist.

# Performance Monitoring Did Not Use a Defined Operational Start Date

**2.75** The Department informed us that it uses a clinic's public announcement date as the baseline for measuring performance. However, clinics may be announced before they begin operating or before additional staffing, services and patient capacity are in place. As a result, the announcement date may not reflect when the collaborative care model became operational.

**2.76** We found that the Department had not established a standardized process for determining each clinic's operational start date or when performance monitoring should begin. This is particularly important because some clinics are newly established, while others involve the expansion or conversion of existing practices.

**2.77** Without a clearly defined and consistently applied operational start date and baseline, the Department may not be able to reliably measure changes in patient attachment, access, service capacity and costs attributable to the collaborative care model. Performance comparisons across clinics and assessments of the model's overall impact may therefore be inconsistent or misleading.

**Recommendation**

**2.78** We recommend that the Department of Health establish and consistently apply a documented operational start date and performance baseline for each collaborative care clinic. These should reflect when the clinic's staffing, services and additional patient capacity became operational and should be used to measure and compare clinic performance.

# Agreements Lacked Funding Recovery Provisions

**2.79** Funding for collaborative care clinics includes several components that are directly linked to physician or team patient panel sizes, including support for overhead, medical office assistants, nursing services and allied health professionals. As patient panel size thresholds increase, clinics may become eligible for higher levels of funding and staffing support.

**2.80** The Physician Services Agreement provides that funding calculations are to be based on annually adjusted patient panel sizes. This enables the Department to increase or reduce future funding when panel sizes change.

**2.81** However, neither the Physician Services Agreement nor the individual collaborative care clinic agreements included an explicit mechanism to recover funding previously provided when a clinic no longer met the patient panel thresholds that supported the original funding level.

**2.82** Without clear recovery provisions, the Department may be unable to recover funding that exceeds the level supported by actual patient panel sizes. This increases the risk that public funding is not consistently aligned with the services delivered, program requirements or intended clinic capacity.

**Recommendation**

**2.83** We recommend that the Department of Health strengthen its collaborative care clinic funding agreements by:

- establishing a formal process to regularly monitor and validate physician and team patient panel sizes
- adjusting funding and staffing support when applicable panel thresholds are not maintained
- clearly specifying the circumstances in which excess funding may be recovered

# Lessons Learned Are Not Systematically Identified or Applied

**2.84** Because collaborative care clinics are being implemented on an ongoing basis, the Department should have a formal process to identify, document and apply lessons learned from each clinic rollout. Regular reviews of implementation challenges, successful practices, costs and performance results would help the Department refine its approach, avoid repeating problems and improve the planning and effectiveness of future clinics.

**2.85** The Department informed us that it had identified lessons learned from previous care models and research from other jurisdictions. However, we were unable to obtain documented evidence demonstrating how these lessons had been assessed, incorporated into planning or applied to subsequent clinic openings.

**2.86** The Collaborative Care Clinic Accountability Agreement requires quarterly meetings between the parties to the agreement to evaluate the clinic's progress against agreed-upon targets as well as focus on opportunities for improvement. We were informed by the Department that while the meetings were taking place there was no formalized mechanism to evaluate the results and use this for program improvement.

**Recommendation**

**2.87** We recommend that the Department of Health establish and implement a formal process to:

- identify and document lessons learned from collaborative care clinic implementation, including challenges, successful practices, costs and performance results
- assess the results of quarterly clinic review meetings and other implementation experience
- assign responsibility and timelines for addressing identified issues
- apply relevant lessons to the planning, funding, rollout and ongoing improvement of existing and future collaborative care clinics

# Appendix I:

## RECOMMENDATIONS AND RESPONSES

| Par. # | Recommendation | Entity's Response | Target Implementation Date |
|---|---|---|---|
| We recommend that the Department of Health: | | | |
| 2.20 | develop and implement a provincial plan that uses documented community health needs and access gaps to guide the implementation, funding and resourcing of collaborative care clinics and identifies how unmet needs will be addressed in areas where physicians do not voluntarily adopt the model. | **Agree**<br>The Department of Health will request the Regional Health Authorities (RHAs) document how they are using community health needs assessments to identify access gaps, and how this information informs planning, priority setting and decision making. Furthermore, the Department will request the RHAs submit their plans to address unmet needs in communities. | 2027-06-30 |
| 2.27 | complete and regularly update a comprehensive financial analysis of the collaborative care model covering both the current four-year agreement term and the period beyond it. The analysis should include operational support, infrastructure and implementation costs, and assess the financial impact of different patient panel sizes and physician participation rates. | **Agree**<br>The Department will complete and regularly update a comprehensive financial analysis of the collaborative care model covering both the current four-year agreement term and the period beyond it. | 2027-06-30 |
| 2.36 | ensure consistent application of established performance targets to all collaborative care physicians. Any approved variation should be supported by documented criteria and rationale. | **Agree**<br>The Department of Health will request the consistent application of established performance targets for all collaborative care physicians and Nurse Practitioners. Example: where a physician's performance target is set below the standard full-time equivalent (FTE) target of 1,400 patients, the Department will require supporting documentation outlining the physician's approved FTE commitment. | 2026-09-30 |

| Par. # | Recommendation | Entity's Response | Target Implementation Date |
|---|---|---|---|
| 2.49 | establish and apply a documented methodology to accurately identify, validate and report the number of patients newly attached through collaborative care clinics. | **Agree**<br>The Department of Health, as noted in the report, implemented a new method for tracking attached patients effective April 1, 2026. Physicians and Nurse Practitioners must manage their rosters of patients through the Medicare Claims Entry billing system. This will allow the department to track attached patients and will be used to validate the accuracy of performance data reporting moving forward. | 2027-01-01 |
| 2.50 | establish clear criteria for assessing whether clinics are on track and verify accuracy of performance data. | **Agree**<br>The Department of Health in partnership with the RHAs will establish and monitor clear criteria to measure if the clinic is on track to meet attachment expectations. | 2026-09-30 |
| 2.57 | require the Regional Health Authorities to report complete and reliable visit data by physician. The Department should regularly compare actual results with established targets. | **Agree**<br>The Department will require the RHAs to report complete and reliable physician-level visit data and will regularly compare actual results against established targets. Follow up with the RHAs will be done for those physicians not meeting targets. | 2027-01-01 |

| Par. # | Recommendation | Entity's Response | Target Implementation Date |
|---|---|---|---|
| 2.62 | strengthen its monitoring of collaborative care clinics by:<br>• establishing interim milestones and expected performance trajectories for each clinic<br>• obtaining complete and reliable performance information, including patient visits by physician<br>• defining thresholds that trigger further review, improvement plans or corrective action<br>• regularly assessing clinic results against established targets and taking timely action where performance is below expectations | **Agree**<br>The Department of Health will work with the RHAs to:<br>• Establish interim milestones and expected performance trajectories for each collaborative care clinic to support ongoing monitoring and accountability.<br>• Obtain complete and reliable performance information, including patient visits by physician, to support accurate assessment of clinic activity.<br>• Define thresholds that will trigger further review, improvement plans, or corrective action where performance concerns are identified.<br>• Regularly assess clinic performance against established targets and take timely action where results are below expectations. | 2027-06-30 |
| 2.69 | • finalize and implement a reliable process to identify and regularly report the number and geographic distribution of New Brunswick residents without a primary care provider<br>• assess the collaborative care model's expected contribution to reducing the number of unattached residents<br>• identify how remaining unmet primary care needs will be addressed through other initiatives and resources | **Agree**<br>• The Department of Health is developing a process to identify and regularly report the number and geographic distribution of New Brunswick residents without a primary care provider.<br>• The Department of Health, as noted in the report, implemented a new method for tracking attached patients effective April 1, 2026. This method will be used to identify those residents attached to a collaborative care clinic.<br>• The Department of Health in collaboration with the RHAs and health system partners will analyze regional unmet care needs to identify areas with the highest demand and determine the most appropriate strategies and resource allocations to address service gaps effectively. | 2027-04-01 |

| Par. # | Recommendation | Entity's Response | Target Implementation Date |
|---|---|---|---|
| 2.74 | track and verify whether patients newly attached through collaborative care clinics were previously on the provincial waitlist and use this information to assess and report the model's impact on reducing the waitlist. | **Agree**<br>The Department of Health will resume oversight of the NB Health Link Patient Registry and will develop a process to track and verify whether patients newly attached through collaborative care clinics were previously on the provincial waitlist. | 2027-09-30 |
| 2.78 | establish and consistently apply a documented operational start date and performance baseline for each collaborative care clinic. These should reflect when the clinic's staffing, services and additional patient capacity became operational and should be used to measure and compare clinic performance. | **Agree**<br>The Department of Health, in collaboration with the RHAs and primary care providers, will establish a consistent operational start date and performance baselines for each collaborative care clinic to support accurate measurement. | 2026-10-30 |
| 2.83 | strengthen its collaborative care clinic funding agreements by:<br>• establishing a formal process to regularly monitor and validate physician and team patient panel sizes<br>• adjusting funding and staffing support when applicable panel thresholds are not maintained<br>• clearly specifying the circumstances in which excess funding may be recovered | **Agree**<br>The Department will work with the RHAs to strengthen collaborative care clinic funding agreements. | 2027-04-01 |

| Par. # | Recommendation | Entity's Response | Target Implementation Date |
|---|---|---|---|
| 2.87 | establish and implement a formal process to:<br>• identify and document lessons learned from collaborative care clinic implementation, including challenges, successful practices, costs and performance results<br>• assess the results of quarterly clinic review meetings and other implementation experience<br>• assign responsibility and timelines for addressing identified issues<br>• apply relevant lessons to the planning, funding, rollout and ongoing improvement of existing and future collaborative care clinics | **Agree**<br>The Department of Health in collaboration with the RHAs will develop a formal process to document lessons learned, assess quarterly clinic results and document actions for resolving issues. | 2027-04-01 |

# Appendix II: Audit Objective and Criteria

The objective and criteria for our audit of the Department of Health are presented below. The Department of Health and its senior management reviewed and agreed with the objective and associated criteria.

| | |
|---|---|
| **Objective** | **To determine if the Department of Health's expansion of collaborative care clinics in New Brunswick was planned, implemented, and monitored to increase access to primary care where it is needed most.** |
| Criterion 1 | The Department of Health planned and implemented collaborative care clinics based on documented community health needs and access gaps. |
| Criterion 2 | The Department of Health has used insights from implemented clinics to inform expansion decisions of collaborative care clinics. |
| Criterion 3 | The Department of Health uses performance indicators, targets, and reporting to measure attachment and access to primary care providers and the impact of collaborative care clinics on this access. |
| Criterion 4 | The Department of Health has demonstrated impact to patient attachment and timely access to primary care through collaborative care clinics consistent with expected outcomes. |

# Appendix III: Independent Assurance Report

This independent assurance report was prepared by the Office of the Auditor General of New Brunswick (AGNB) on the Department of Health and the collaborative care clinic expansion. Our responsibility was to provide objective information, advice, and assurance to assist the Legislative Assembly in its scrutiny of the Department of Health with respect to the collaborative care clinic expansion.

All work in this audit was performed to a reasonable level of assurance in accordance with the Canadian Standard on Assurance Engagements (CSAE) 3001 – Direct Engagements set out by the Chartered Professional Accountants of Canada (CPA Canada) in the CPA Canada Handbook – Assurance.

AGNB applies the Canadian Standard on Quality Management 1 – Quality Management for Firms that Perform Audits or Reviews of Financial Statements, or Other Assurance or Related Services Engagements. This standard requires our office to design, implement and operate a system of quality management, including policies or procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

In conducting the audit work, we have complied with the independence and other ethical requirements of the Rules of Professional Conduct of Chartered Professional Accountants of New Brunswick and the Code of Professional Conduct of the Office of the Auditor General of New Brunswick. Both the Rules of Professional Conduct and the Code are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

In accordance with our regular audit process, we obtained the following from management:

- confirmation of management's responsibility for the subject under audit
- acknowledgement of the suitability of the criteria used in the audit
- confirmation that all known information that has been requested, or that could affect the findings or audit conclusion, has been provided
- confirmation that the findings in this report are factually based

## PERIOD COVERED BY THE AUDIT

The audit covered the period between April 1, 2025 and March 31, 2026. This is the period to which the audit conclusion applies. However, to gain a more complete understanding of the subject matter of the audit, we also examined certain matters outside of this period as deemed necessary.

## DATE OF THE REPORT

We obtained sufficient and appropriate audit evidence on which to base our conclusion on August 31, 2026, in Fredericton, New Brunswick.

NB POWER

2026

# Rate Rider Surcharge

**Chapter 3**

**Volume II: Independent Information Report**

AUDITOR GENERAL OF NEW BRUNSWICK
VÉRIFICATEUR GÉNÉRAL DU NOUVEAU-BRUNSWICK

# Table of Contents



# NB Power

## RATE RIDER SURCHARGE


# Chapter 3 Highlights

| | | |
|---|---|---|
| Forecast risk has shifted from NB Power to ratepayers | Underlying financial challenges remain | Costs continue to accumulate |
| Recovery is being deferred to future ratepayers | | |

**OVERALL CONCLUSION:** The variance account framework has protected NB Power's financial results by transferring forecast risk to ratepayers, yet deferred balances continue to grow, recovery periods are extending, and the underlying financial challenges remain unresolved.

# Results at a Glance

## RATE RIDER SURCHARGE

**Ratepayers are increasingly bearing financial risks while underlying financial challenges persist**

| FINDINGS | |
|---|---|
|  | Amendments to the *Electricity Act* in 2021 **ensure** certain differences between forecasts and actuals incurred are **recovered** |
|  | Regulatory changes **requested by NB Power** |
|  | Net variance account balance has grown to **$384 million in 4 years** |
|  | Variance accounts have increased reported net earnings by **$384 million** |
|  | Net earnings and percentage of net debt in capital structure targets **have not been met** in years following implementation |
|  | Recovery period has extended cost **deferral to future ratepayers** from 2 years to 8 years |
|  | Additions to the variance account balance **exceeded amounts recovered** from ratepayers in 2 of 3 years |

# Introduction

**3.1** NB Power is a provincially owned Crown corporation responsible for generating, transmitting, and distributing electricity in New Brunswick. As such, its forecasting and control of power generation-related costs directly affects its financial performance, long-term planning and the cost of electricity for New Brunswickers.

**3.2** This report examines NB Power's rate rider, a legislated surcharge or credit on ratepayers' bills that reflects differences between forecasted and actual costs and sales.

**3.3** As of March 31, 2026, the net variance account balance to be recovered from customers through the rate rider was $384 million.

**3.4** The *Regulatory Variance Accounts and Deferral Account Regulation 2022-17* (the Regulation) under the *Electricity Act* establishes how and when variances are recovered from, or reimbursed to ratepayers. This report examines the rate rider framework, including trends in variance account balances, recovery periods, and progress toward intended outcomes.

## WORK PERFORMED

**3.5** This report is informational in nature and does not provide audit assurance. Our work included reviewing documentation supplied by NB Power to the New Brunswick Energy and Utilities Board (EUB) as well as internal documentation and conducting interviews with staff and executives from NB Power and the Department of Energy.

**3.6** While this report focuses on residential customers for illustration purposes, all customer classes are impacted through similar rate adjustment mechanisms.

# Background and Regulatory Context

## ELECTRICITY RATE SETTING (PRE-ACCOUNTS)

**3.7** Customer electricity rates are established based on the annually forecasted cost of providing service. NB Power estimates future costs, including energy supply, generation, transmission, and distribution, and these projected costs form the basis for rate setting.

**3.8** This process is overseen by the EUB through the General Rate Application. The objective of this oversight is to approve the recovery of prudent and necessary costs while maintaining financial stability.

**3.9** Accordingly, electricity charges to be collected from ratepayers are based on future forecasted costs at the time of the General Rate Application.

**3.10** NB Power reports that its complex operating environment results in significant portions of net earnings being outside management control, creating the potential for year-to-year variability. Key drivers of variability were noted as follows:

- customer demand
- weather events
- hydro flows
- external market conditions
- nuclear generation station performance

**3.11** It was reported that during the period 2016 to 2020 the total budget variance was approximately $300 million over budget. The impact of these differences was recognized in NB Power's earnings in the year incurred.

**3.12** There was no legislated mechanism to recover historical forecast variances. Recovery depended on creating other revenue streams or improving the utility's performance to manage costs.

**3.13** Under this framework, NB Power initially absorbed forecast variances through its earnings, bearing the financial consequences and retaining a direct incentive to improve forecasting.

## LEGISLATIVE CHANGES FOR VARIANCE ACCOUNTS AND RATE RIDERS

**3.14** In 2019, prior to the legislative changes, NB Power proposed a deferral account for demand-side management costs. The EUB rejected the proposal, finding it was not in the public's best interest because it could:

- allow deferred and carrying costs to build over time
- shift costs to future ratepayers
- lead to higher long-term rates despite short-term rate smoothing

**3.15** A project team led by NB Power and the then Department of Natural Resources and Energy Development developed options for a legislative variance account framework through 2020 and 2021.

**3.16** On November 10, 2021, an amendment to the *Electricity Act* established two regulatory variance accounts to capture the differences between actual and forecasted electricity sales and supply costs effective April 1, 2022.

**3.17** The request for these regulatory variance accounts was not made to the EUB and the amendment was subsequently approved by the provincial government through Bill number 77 on December 17, 2021.

**3.18** The regulatory variance accounts are intended to protect net earnings from variances in revenues and supply costs that arise due to NB Power's complex and unpredictable business environment. The two accounts established were:

- the electricity sales and margin variance account
- the energy supply cost variance account

**3.19** The electricity sales and margin variance account records the difference between actual and forecasted in-province electricity sales and out-of-province gross margin.

**3.20** The energy supply cost variance account records the difference between actual and forecasted fuel and purchased power costs incurred to supply in-province customers.

**3.21** The net balance of these two variance accounts is combined to determine the rate rider. A net balance results in either a surcharge or a credit to ratepayers:

| | | | |
|---|---|---|---|
|  | Net Positive Balance (Costs higher or sales lower than expected) |  | Net Negative Balance (Costs lower or sales higher than expected) |
| Ratepayers pay a **surcharge** to recover the difference | | Ratepayers receive a **credit** to refund the difference | |

**3.22** The variance accounts carry forward their balance each year. Every year, NB Power files with the EUB to determine:

- the amount to be recovered or reimbursed in the year
- the years over which recovery or reimbursement will occur
- the rate rider (cents/kWh) applied to customer bills

**3.23** Legislation limits the EUB's discretion over which amounts may be recorded in the variance accounts. Subsection 117.4(6) of the *Electricity Act* deems variances calculated under the Act and regulations to be prudent and necessary.

**3.24** As a result, amounts recorded in the variance account are effectively approved for recovery from, or reimbursement to ratepayers without further EUB prudence review.

**3.25** Under this framework, when unfavorable variances arise between actual and forecasted sales and margin or costs, the amount of the variance is deferred and later recovered from ratepayers. This mechanism protects NB Power's net earnings from variability associated with these costs and shifts financial risk related to forecasting to future ratepayers.

3.26 The following flowcharts illustrate how differences between forecasted and actual costs are treated before and after the establishment of the variance accounts:

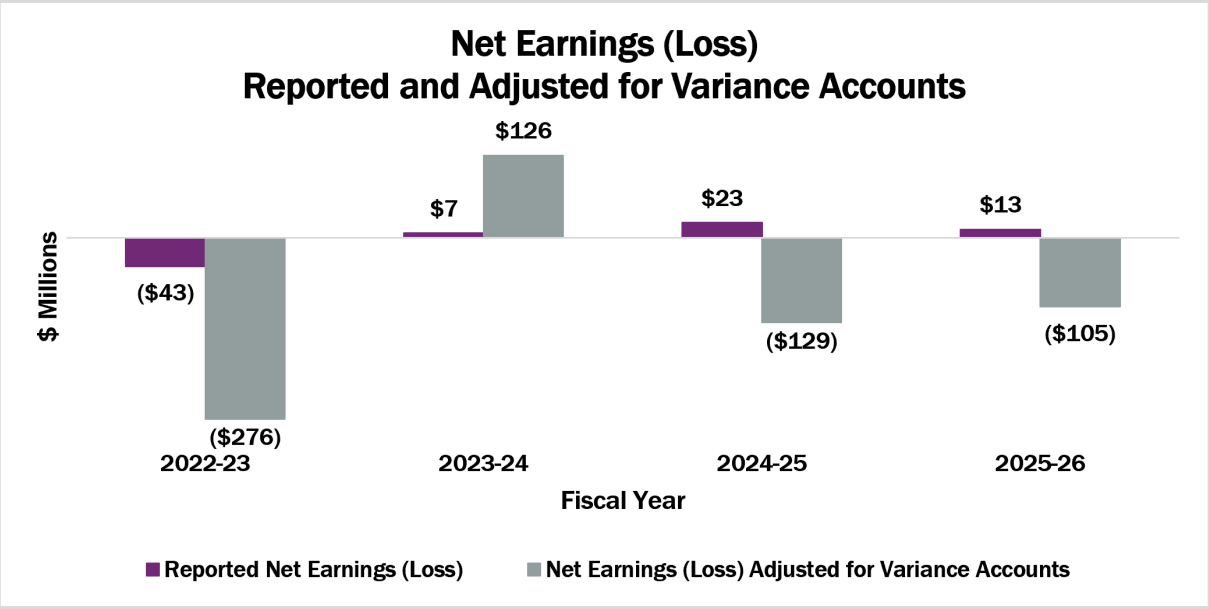
| BEFORE REGULATORY ACCOUNTS<br>(Forecast Risk with NB Power) | AFTER REGULATORY ACCOUNTS<br>(Forecast Risk Shifted to Ratepayers) |
|---|---|
| **Forecast to actual variance**<br>**(higher costs or lower revenues)**<br>Actual results differ from forecast. | **Forecast to actual variance**<br>**(higher costs or lower revenues)**<br>Actual results differ from forecast. |
| ↓ | ↓ |
| **Lower profit for NB Power**<br>The difference hits earnings immediately. | **Deferred to regulatory asset**<br>The difference is recorded as a regulatory asset (variance account). |
| ↓ | ↓ |
| **EUB approves future electricity rates**<br>Rates based on prudent forecast costs. | **EUB sets rules and approves recovery**<br>The EUB approves the amount and recovery period under the framework rules. |
| ↓ | ↓ |
| **No dedicated recovery mechanism**<br>Historical forecast variances were not recoverable through rates. | **Recovery through rate riders**<br>The balance (plus interest) is recovered from customers through a rate rider. |
| ↓ | ↓ |
| **Customers do not pay through rates**<br>Customers do not pay for forecast variances through electricity rates. | **Customers repay over time**<br>Customers pay a surcharge (or receive a credit) on their bills over the approved period. |

3.27 These changes shift the timing and location of risk, reducing the impact of forecast variances on NB Power's earnings while increasing reliance on recovery from ratepayers over time.

# Financial Outcomes Not Being Met

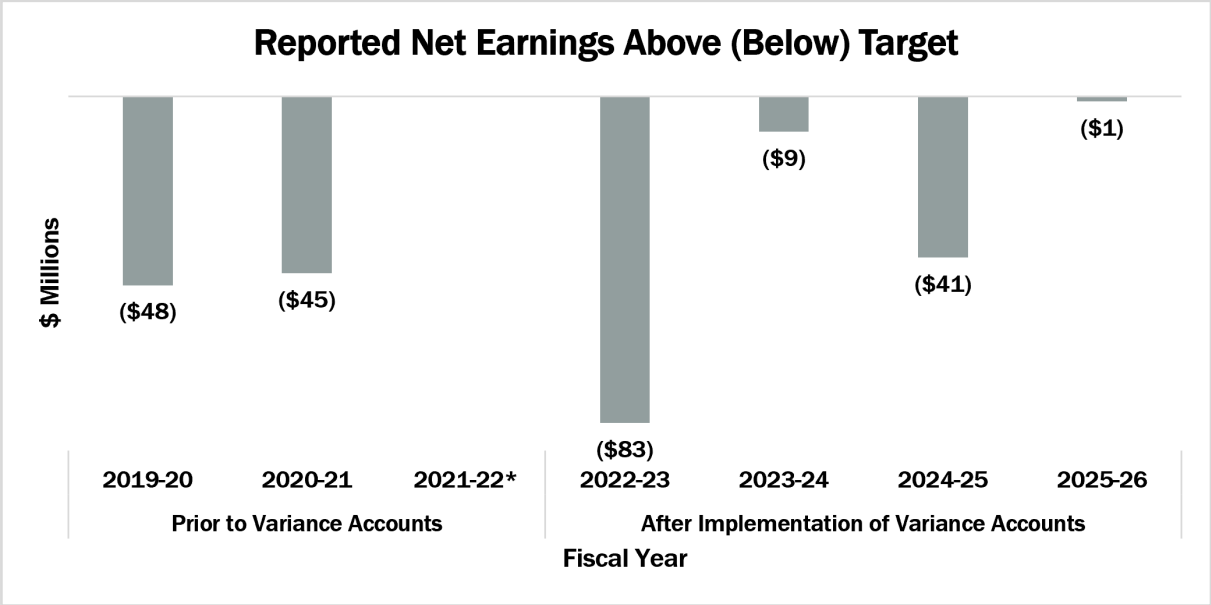
**3.28** NB Power has reported that the changes to the legislation for the variance account framework will reduce variability in net earnings and support consistent achievement of financial targets, such as net earnings and the percentage of net debt in capital structure.

**3.29** Since implementation, the variance account framework has increased net earnings by $384 million. The following graph shows the impact on reported net earnings based on the annual change in variance account balances and recoveries recognized through rate riders:



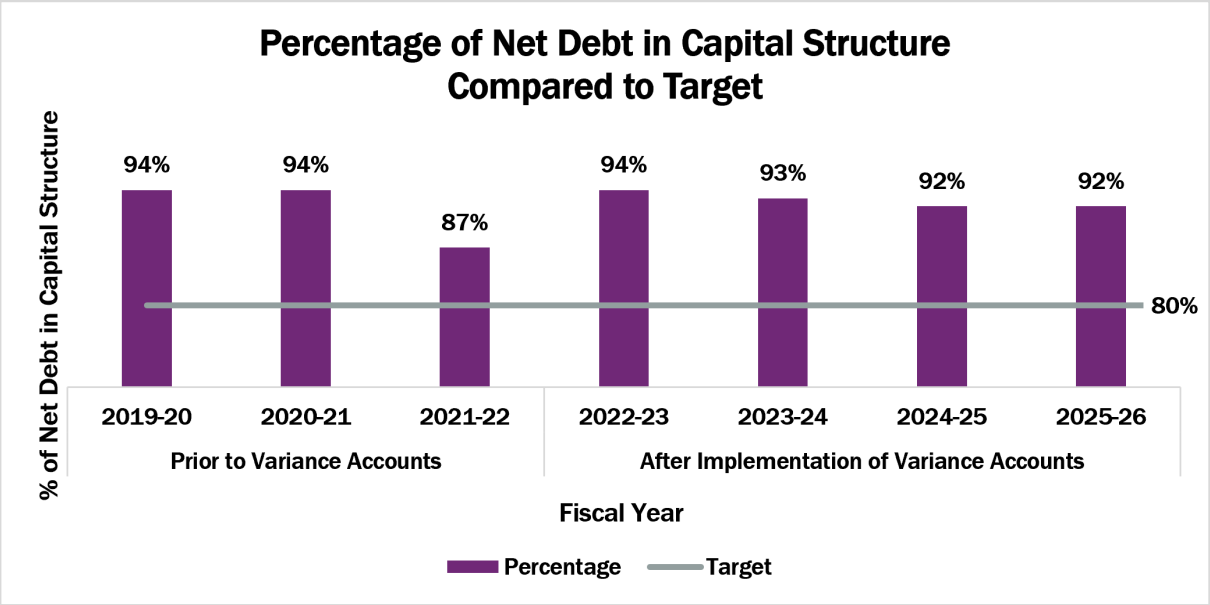

*Source: Prepared by AGNB based on data from NB Power Annual Financial Statements (unaudited)*

3.30 While the variance account framework materially affected reported net earnings, NB Power has not met its established target in any of the four fiscal years since implementation. Net earnings (loss) fell below target by amounts ranging from $1 million to $83 million:



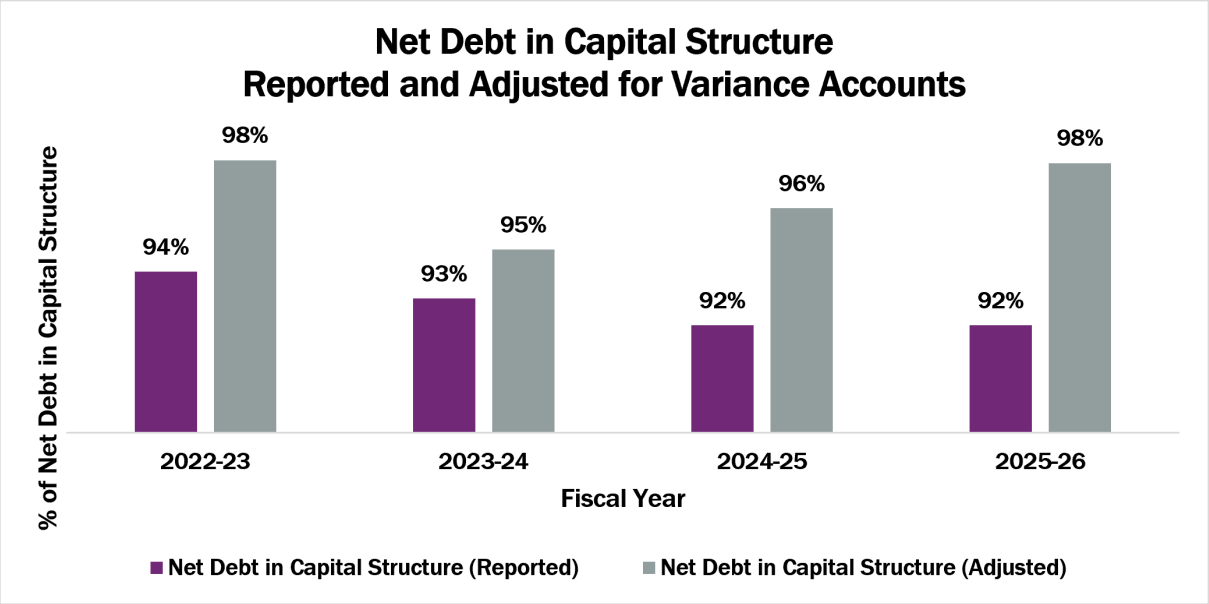

*Source: Prepared by AGNB based on data from NB Power Annual Financial Statements (unaudited)*
**In 2021-22, NB Power did not set a target for net earnings and instead reported against an operating earnings target.*

3.31 Similarly, NB Power's percentage of net debt in capital structure remained above its 80% target in all years:




*Source: Prepared by AGNB based on data from NB Power Annual Financial Statements (unaudited)*

**3.32** The variance account framework increased reported net earnings by approximately $384 million since implementation. By preserving retained earnings, the framework also improved NB Power's reported percentage of net debt in capital structure by six percentage points in 2025-26. The following graph compares the reported percentage of net debt in capital structure to an illustrative percentage adjusted for the regulatory variance accounts:

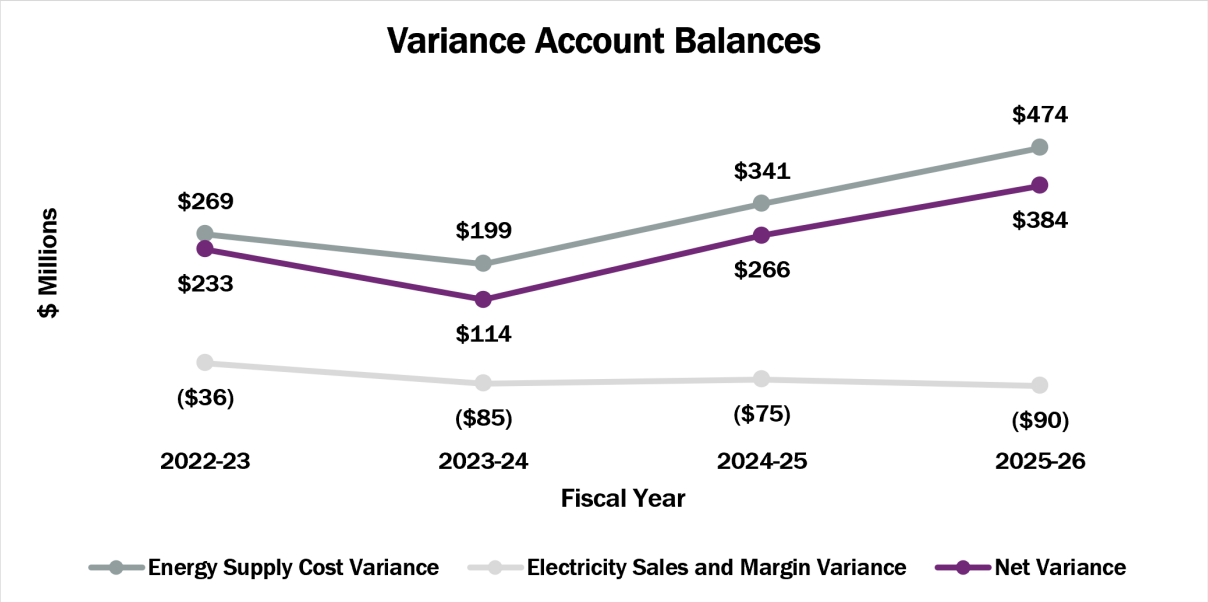



*Source: Prepared by AGNB based on data from NB Power Annual Financial Statements (unaudited)*

# Risks Associated with Deferral Accounts Are Materializing

## GROWTH OF VARIANCE ACCOUNT SHOWS COSTS BUILDING OVER TIME

**3.33** Since the introduction of the variance accounts, the total balance has grown to $384 million. The following graph shows the growth in the balances from the time of implementation:




*Source: Prepared by AGNB based on data from NB Power (unaudited)*

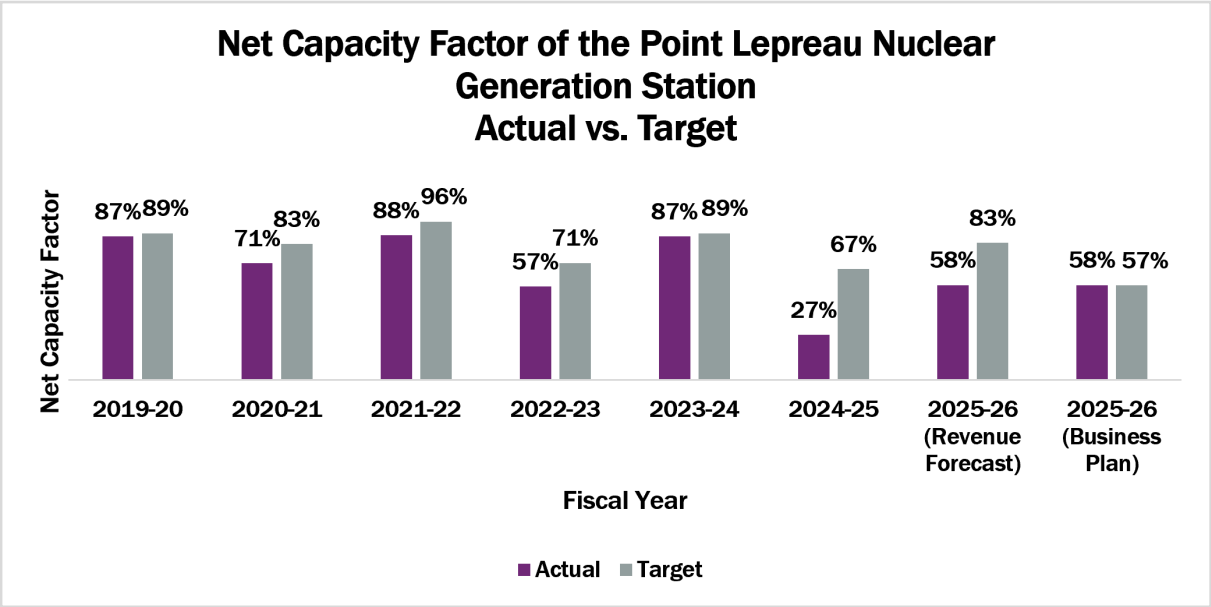
**3.34** Although the electricity sales and margin variance account has remained relatively stable, growth in the total balance has been driven by variances in the energy supply cost variance account.

**3.35** NB Power's annual variance account recovery filings identify key drivers for the increases in the energy supply cost variance account:

- 4/4 filings identified outages at the Point Lepreau Nuclear Generation Station
- 2/4 filings identified lower hydro generation

**3.36** NB Power reports that these key drivers have resulted in cost overruns as they required NB Power to acquire higher-cost replacement fuel and power.

**3.37** The performance of Point Lepreau Nuclear Generation Station is repeatedly cited for its impact on net earnings. The following graph shows that over the past seven fiscal years, its performance net capacity factor target has consistently not been met:




*Source: Prepared by AGNB based on data from NB Power Annual Financial Statements (unaudited)*

*Note: 2025-26 (Revenue Forecast) is the target initially set based on a two-year forecast. 2025-26 (Business Plan) is the target subsequently set in NB Power's annual business plan.*

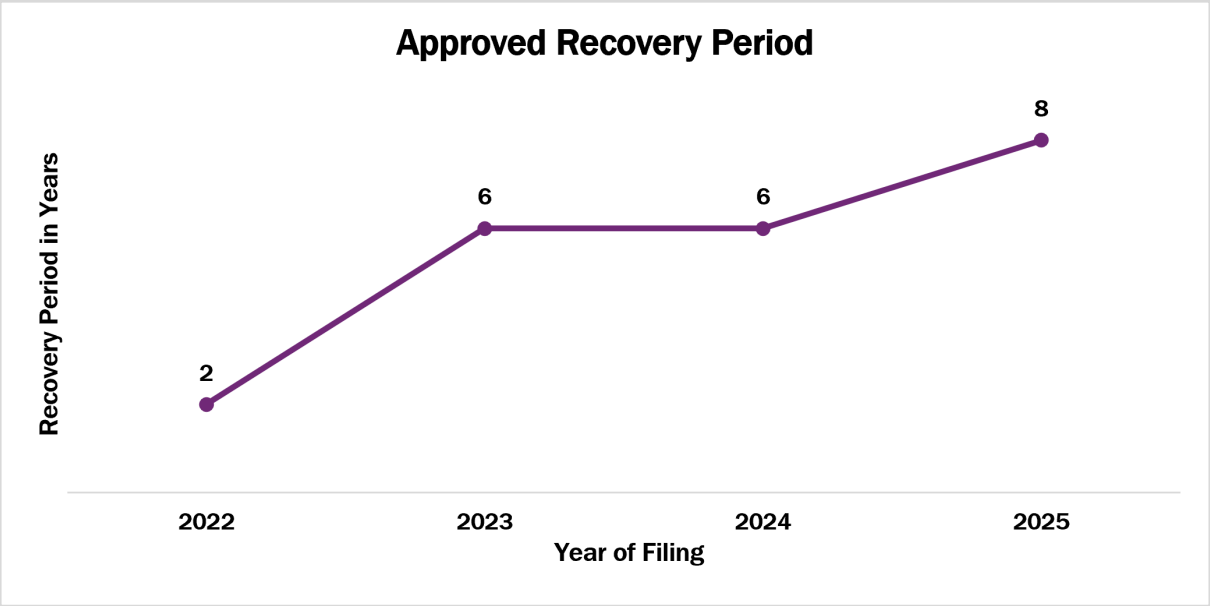
**3.38** According to NB Power, outages at the Point Lepreau Nuclear Generating Station result in increased costs due to the need to procure higher-cost replacement energy.

**3.39** The unplanned outage at Point Lepreau Nuclear Generating Station in 2024-25 added an estimated $143 million in replacement power costs.

## INCREASING COST BURDEN ON FUTURE RATEPAYERS

**3.40** The recovery period of the variance account balance that is approved by the EUB is based on the recovery or reimbursement calculations set out in the Regulation. Subsection 12(4) limits annual recoveries to no more than 3% of forecasted in-province revenue. In each of the three years where a recovery was approved, the recovery equaled the maximum amount permitted under the Regulation.

**3.41** As the variance account balance has increased, the recovery period has also expanded. The following graph shows the annual approved recovery period for variance account amounts to be collected from ratepayers increasing from two to eight years:




*Source: Prepared by AGNB based on data from NB Power (unaudited)*

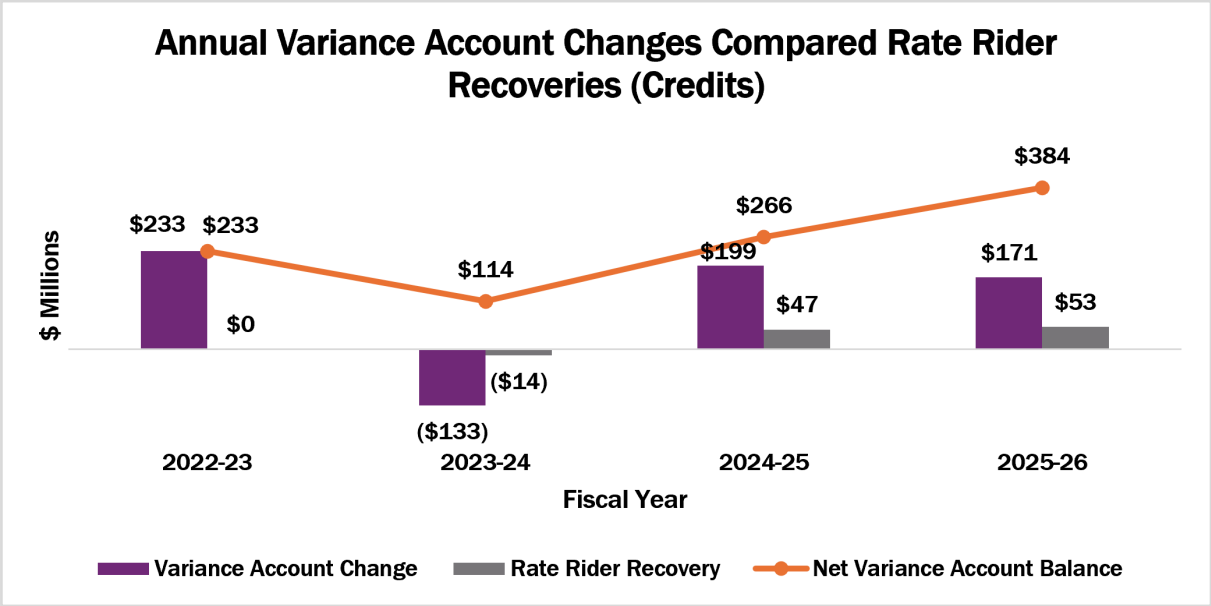
**3.42** As of October 31, 2025, the balance is expected to be recovered over eight years, through fiscal 2033-34. However, legislation does not limit the length of the recovery period.

**3.43** The growth in both the variance account balance and the recovery period increases the extent to which amounts added to the balance are deferred and shifts the financial burden to future ratepayers.

## GROWTH OF VARIANCE ACCOUNT EXCEEDS RECOVERY

**3.44** As of March 31, 2026, net additions of $437 million and associated interest of $33 million have been offset by $86 million in recoveries since implementation. As a result, the variance account balance has grown to $384 million over four years. This growth raises concerns about whether recoveries subject to the Regulation's 3% maximum recovery are keeping pace with ongoing additions to the balance.

**3.45** The following graph compares annual changes to the variance account balance, including interest, to amounts recovered from (returned to) ratepayers through rate riders:




*Source: Prepared by AGNB based on data from NB Power (unaudited)*

**3.46** In two of three fiscal years, annual increases to the variance account balance exceeded amounts recovered from ratepayers. In 2025-26, additions exceeded recoveries by $118 million.

**3.47** As a result, the variance account balance has continued to grow despite ongoing collections through rate riders. Where annual additions exceed recoveries, balances will continue to accumulate, extending recovery periods and increasing the amount of costs deferred to future ratepayers.

**3.48** At October 31, 2025, the variance account balance is expected to be recovered over eight years. While NB Power expects full recovery under the current legislative framework, continued growth in the balance could further extend recovery periods.

**3.49** Larger balances held over longer periods may increase NB Power's reliance on debt or other financing to cover costs not yet recovered from customers, resulting in additional interest and financing costs.

## IMPACT ON RESIDENTIAL RATEPAYERS

**3.50** Residential customers can identify the rate rider surcharge on their bills under the "Variance account amount for electricity you used" section as shown in Appendix II.

**3.51** The rate rider surcharge is separate from the standard electricity usage charge and is applied as an additional cents-per-kilowatt-hour charge (c/kWh).

**3.52** Based on the example bill provided from February 2025 in Appendix II, the residential electricity rate was 13.46 c/kWh, while the monthly rate rider surcharge was approximately 0.38 c/kWh. The rate rider increased the amount charged for electricity usage by 2.82%.

**3.53** The customer shown in Appendix II paid $11.10 in rate rider charges for the month. Should electricity consumption remain the same for the year, this would amount to an annual total of approximately $133.20.

**3.54** If the variance account balance continues to grow, ratepayers may face increasing surcharge amounts over time, contributing to higher overall electricity costs.

# Conclusion

**3.55** The variance account framework has significantly reduced the impact of cost and revenue variances on NB Power's annual financial results by allowing these amounts to be deferred and recovered from ratepayers over time.

**3.56** Since implementation, the variance account framework has increased reported net earnings by approximately $384 million and improved reported financial indicators. However, NB Power has continued to fall short of its established financial targets, suggesting the underlying financial and operational challenges remain unresolved.

**3.57** The net balance of deferred costs has grown faster than recoveries, extending the recovery period from two to eight years.

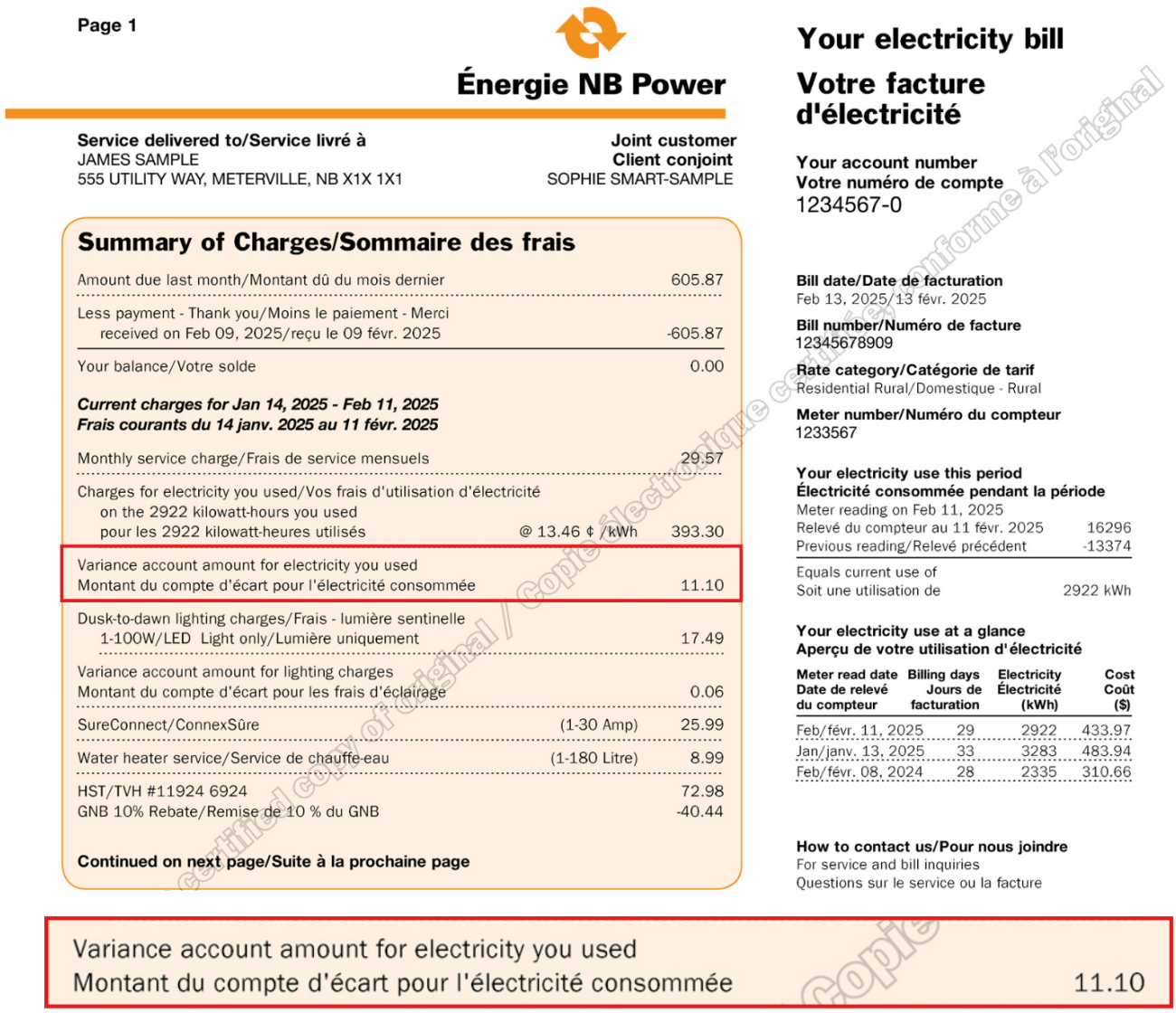
**3.58** While the legislative framework provides for recovery of these balances from ratepayers, it limits the EUB's discretion to review the prudence of amounts recorded in the accounts.

**3.59** Recovery of variance account balances is constrained by the Regulation's 3% recovery cap. The long-term sustainability of the framework therefore depends on NB Power's future operating performance and its ability to limit further additions to the accounts.

# Appendix I: Summary Timeline

| Date | Milestone |
|---|---|
| **July 16, 2019** | EUB denies NB Power's request for a regulatory deferral account. |
| **2020 - 2021** | NB Power and the then Department of Natural Resources and Energy Development develop options for a legislative regulatory variance account framework. |
| **November 10, 2021** | Bill 77 introduced, proposing amendments to establish regulatory variance accounts. |
| **December 17, 2021** | Bill 77 receives Royal Assent. |
| **April 1, 2022** | Legislative amendments establishing the regulatory variance account framework come into force. |

# Appendix II: Sample Residential Bill



Page 1

Énergie NB Power

**Service delivered to/Service livré à**
JAMES SAMPLE
555 UTILITY WAY, METERVILLE, NB X1X 1X1

**Joint customer**
**Client conjoint**
SOPHIE SMART-SAMPLE

## Summary of Charges/Sommaire des frais

| | | |
|---|---|---|
| Amount due last month/Montant dû du mois dernier | | 605.87 |
| Less payment - Thank you/Moins le paiement - Merci received on Feb 09, 2025/reçu le 09 févr. 2025 | | -605.87 |
| Your balance/Votre solde | | 0.00 |
| ***Current charges for Jan 14, 2025 - Feb 11, 2025*** | | |
| ***Frais courants du 14 janv. 2025 au 11 févr. 2025*** | | |
| Monthly service charge/Frais de service mensuels | | 29.57 |
| Charges for electricity you used/Vos frais d'utilisation d'électricité on the 2922 kilowatt-hours you used pour les 2922 kilowatt-heures utilisés | @ 13.46 ¢ /kWh | 393.30 |
| Variance account amount for electricity you used Montant du compte d'écart pour l'électricité consommée | | 11.10 |
| Dusk-to-dawn lighting charges/Frais - lumière sentinelle 1-100W/LED Light only/Lumière uniquement | | 17.49 |
| Variance account amount for lighting charges Montant du compte d'écart pour les frais d'éclairage | | 0.06 |
| SureConnect/ConnexSûre | (1-30 Amp) | 25.99 |
| Water heater service/Service de chauffe-eau | (1-180 Litre) | 8.99 |
| HST/TVH #11924 6924 | | 72.98 |
| GNB 10% Rebate/Remise de 10 % du GNB | | -40.44 |

**Continued on next page/Suite à la prochaine page**

## Your electricity bill

## Votre facture d'électricité

**Your account number**
**Votre numéro de compte**
1234567-0

**Bill date/Date de facturation**
Feb 13, 2025/13 févr. 2025

**Bill number/Numéro de facture**
12345678909

**Rate category/Catégorie de tarif**
Residential Rural/Domestique - Rural

**Meter number/Numéro du compteur**
1233567

**Your electricity use this period**
**Électricité consommée pendant la période**
Meter reading on Feb 11, 2025

| | |
|---|---|
| Relevé du compteur au 11 févr. 2025 | 16296 |
| Previous reading/Relevé précédent | -13374 |
| Equals current use of Soit une utilisation de | 2922 kWh |

**Your electricity use at a glance**
**Aperçu de votre utilisation d'électricité**

| Meter read date Date de relevé du compteur | Billing days Jours de facturation | Electricity Électricité (kWh) | Cost Coût ($) |
|---|---|---|---|
| Feb/févr. 11, 2025 | 29 | 2922 | 433.97 |
| Jan/janv. 13, 2025 | 33 | 3283 | 483.94 |
| Feb/févr. 08, 2024 | 28 | 2335 | 310.66 |

**How to contact us/Pour nous joindre**
For service and bill inquiries
Questions sur le service ou la facture



Variance account amount for electricity you used
Montant du compte d'écart pour l'électricité consommée 11.10

# Appendix III: Independent Information Report

This independent information report was prepared by the Office of the Auditor General of New Brunswick (AGNB) on NB Power and its regulatory variance accounts. This report is not an audit and does not express an audit opinion. Our responsibility was to provide objective information to assist the Legislative Assembly in its scrutiny of NB Power with respect to this initiative. To ensure this report is credible, we obtained confirmation that the information to be reported is accurate from NB Power.

This work was conducted under the authority of the *Auditor General Act.* AGNB applies the Canadian Standard on Quality Management 1 – Quality Management for Firms that Perform Audits or Reviews of Financial Statements, or Other Assurance or Related Services Engagements. This standard requires our office to design, implement, and operate a system of quality management, including policies or procedures regarding compliance with ethical requirements, professional standards, and applicable legal and regulatory requirements.

In conducting our work, we have complied with the independence and other ethical requirements of the Rules of Professional Conduct of Chartered Professional Accountants of New Brunswick and the Code of Professional Conduct of the Office of the Auditor General of New Brunswick. Both the Rules of Professional Conduct and the Code are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality, and professional behaviour.

## DATE OF THE REPORT

We concluded our work on NB Power and its regulatory variance accounts on August 31, 2026, in Fredericton, New Brunswick.


AUDITOR GENERAL
OF NEW BRUNSWICK
VÉRIFICATEUR GÉNÉRAL
DU NOUVEAU-BRUNSWICK

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