How to Conduct a Mid-Year Benefits Utilization Review Before Costs and Employee Needs Drift Too Far

A benefits review should be a decision meeting

Many HR teams receive a benefits utilization report halfway through the year, skim the claims totals, note that costs are up, and file the report until renewal. That is a missed opportunity. A mid-year benefits review should not be a passive broker update or a spreadsheet walk-through. It should be a decision meeting where HR, finance, the benefits advisor and senior leadership identify what the plan data is saying about employee needs, workforce risk and future cost pressure.

The timing matters. By renewal, the insurer or benefits provider has already formed a view of the plan experience, and the employer has less room to respond thoughtfully. Mid-year gives HR time to investigate claims trends, improve communication, adjust training, prepare leaders for renewal, test plan-design options and identify whether high utilization reflects healthier use, unmet workforce need or avoidable cost escalation.

The central principle is simple: benefits utilization data is not just a cost report. It is a workforce signal. If employees are using more mental health support, that may reflect a healthier willingness to seek help, but it may also point to workload, burnout, manager capability or psychological safety concerns. If drug spend is rising, the issue may be medical need, specialty drug pressure, GLP-1 utilization, chronic disease management, plan design or public-program changes. If the EAP is barely used, the plan may be under-communicated, distrusted or poorly matched to employee needs.

Canadian employers cannot treat benefits as a static offering anymore. Costs are rising, employees expect flexibility, disability claims are becoming more complex, mental health needs are more visible and prescription drug trends are putting pressure on plan sustainability. The mid-year review is where HR can still act before the annual renewal conversation becomes only about premium increases.

Why this review matters now

The Canadian benefits environment is under real pressure. **The Canadian Life and**

Health Insurance Association reported that life and health insurers paid out a record $143.3 billion in 2024 for insurance benefits and retirement solutions, up nearly 12% from the previous year. Within health benefits, insurers covered $53.3 billion in total health claims, prescription drugs accounted for $16.6 billion, and paramedical claims such as mental health and massage increased by 16% in 2024.

Those numbers show why benefits are no longer a quiet back-office issue. They are part of total rewards, workforce wellbeing, retention, disability management, accommodation, employee trust and cost governance. A benefits plan that once felt stable can become strained when employees use more high-cost medications, mental health supports, dental services, virtual care, health spending accounts or disability coverage.

Alberta Blue Cross reached a similar conclusion in its 2026 Benefits Pulse Report, which tracks three years of group claims utilization data. The report highlights rising drug spend, growing demand for mental health support, dental and extended health pressure, spending account use, and life and disability trends. It expressly frames utilization data as a way for employers to understand changing employee needs, cost drivers and plan-sustainability questions.

That is the right mindset for HR. A mid-year benefits utilization review should not start with the question, ‘How much did we spend?’ It should start with, ‘What is changing in our workforce, and what does the plan data tell us about where we need to respond?’

Start with the right data package

HR cannot conduct a meaningful review with a single total-claims number. The organization needs a clean, category-level package from its insurer, benefits advisor, EAP provider, disability carrier and internal HR systems. The data must be detailed enough to reveal trends, but aggregated enough to protect privacy and avoid identifying individual employees.

At minimum, HR should request year-to-date data, the same period from the prior year, rolling 12-month comparisons and renewal-assumption comparisons where available. If the workforce is large enough to protect confidentiality, HR may also ask for views by division, location, employee group or plan class. Smaller employers should be careful because overly detailed slices can make individuals identifiable.

The review package should include the following data points where available:

- Extended health claims by category, including paramedical, vision, medical equipment and psychology where available.
- Prescription drug spend, top therapeutic classes, high-cost drugs, specialty drug trends and GLP-1 utilization.
- Dental claims, fee-guide impacts, preventive care patterns and major-service trends.
- Health spending account and wellness spending account utilization, including remaining balances and participation rates.
- EAP or EFAP utilization, issue categories and manager-consultation use where available in aggregate.
- Short-term and long-term disability claim counts, duration trends, primary categories and return-to-work patterns.
- Virtual care, navigation services, wellness platform and preventative program utilization.
- Absence, accommodation, turnover and engagement indicators from internal HR systems that may explain or challenge the benefits trends.

Data quality is part of the review

The first question is whether the data can be trusted. Are terminated employees still showing as covered? Are dependants properly recorded? Are part-time and full-time classifications accurate? Are employees in the correct plan class? Are disability claim dates aligned with HR leave records? Are health spending account balances being reported correctly? Are EAP numbers presented in a way that protects confidentiality but still allows trend analysis?

A surprising number of benefits problems begin with dirty eligibility, payroll or demographic data. If the HRIS and benefits carrier data do not match, the employer may be making plan decisions based on distorted information. Mid-year is the right time to correct those records before renewal and before employees experience claim problems.

Separate cost trends from employee need

The most common mistake is assuming high utilization is bad and low utilization is good. That is too simplistic. Higher utilization may mean employees are receiving care earlier, using preventive dental coverage, accessing mental health support, managing chronic conditions or seeking physiotherapy before an injury becomes a disability claim. In those cases, claims activity may be evidence that the plan is doing part of its job.

Low utilization may look good financially, but it can also be a warning sign. Employees may not understand the benefit, may not trust confidentiality, may be unable to afford co-pays, may lack time for appointments, may be in remote communities with limited providers or may believe the service is not worth using. Low EAP use, for example, does not prove employees are well. It may mean employees do not see the EAP as useful or safe.

The better question is whether utilization matches the workforce risk HR is seeing. If engagement comments mention burnout but mental health supports are barely used, HR should examine awareness, access and stigma. If musculoskeletal claims are rising alongside absenteeism in one job family, HR should look at ergonomics, workload and safety. If prescription drug spend is rising because more employees are managing chronic disease, plan sustainability and employee health may both need attention.

A benefits review becomes valuable when HR interprets the numbers in context rather than treating them as isolated financial facts.

Prescription drugs deserve special attention

Prescription drugs are one of the most important areas to review because they can create rapid cost pressure and employee-relations sensitivity at the same time. Alberta Blue Cross reported that 36% of total benefit costs went toward prescription drugs from January to December 2025. It also reported that total drug spending costs rose just over 7% from 2023 to 2024 and just over 9% from 2024 to 2025, with 62% of members making a drug claim in 2025.

The most important finding is not only that drug costs are rising. It is that a small group of claims can drive a large share of spend. Alberta Blue Cross reported that about 2.1% of claimants used specialty drugs in 2025, yet this group accounted for roughly 28% of total drug spend. The same report identified GLP-1 medications, specialty drugs, newer therapies and chronic-condition treatments as important cost drivers, with semaglutide identified as the top drug by spend for the second year in

a row.

For HR, this creates a difficult balance. The organization should not respond reflexively by cutting coverage or shifting costs without understanding what employees need. High-cost drugs may be life-changing or medically necessary. They may also require careful plan management, special authorization, step therapy, biosimilar strategies, generic substitution, coordination with public programs or clearer communication about coverage rules.

A mid-year drug review should ask practical questions before renewal pressure arrives. Which drug categories are driving spend? Are costs rising because of more claimants, higher costs per claimant or a small number of high-cost drugs? Are GLP-1 drugs being used for diabetes, obesity or both? Are specialty drug claims increasing because more conditions are eligible for biologics or advanced therapies? Are there plan-design tools in place, and are they being used properly? What employee-relations risks would arise if coverage were changed?

The goal is not to turn HR into a pharmacy-benefits expert. The goal is for HR to understand enough to ask better questions and explain the issue to leadership without reducing it to ‘drug costs are up.’

Mental health utilization needs deeper interpretation

Mental health is one of the hardest benefits categories to interpret because the same utilization pattern can mean different things. Rising psychology, counselling or EAP use may indicate that employees are struggling. It may also indicate that employees are less ashamed to seek help, that coverage is finally adequate, that managers are referring employees earlier or that the organization has communicated supports more effectively.

Alberta Blue Cross reported that psychology has become one of the fastest-growing paramedical benefits, with spending increasing by almost 35% over three years as more plan members access support more often. The report connects that trend to mental health needs, reduced stigma, expanded provider options and richer plan coverage.

HR should compare mental health utilization with disability claims, absenteeism, employee engagement comments, workload data, harassment complaints, accommodation requests and turnover risk. If mental health claims rise while disability durations are stable or falling, early support may be helping. If mental health claims rise along with burnout comments, turnover and long disability leaves, the plan may be responding to symptoms while the workplace continues to create strain.

A mid-year review should also ask whether mental health coverage is sufficient to be meaningful. A plan may technically cover counselling, but low maximums, reimbursement delays, provider shortages or unclear eligibility may prevent employees from using it effectively. HR should also review whether employees know the difference between EAP, extended health counselling, virtual mental health services, disability benefits, accommodation and leave.

The strongest employers do not treat mental health benefits as a substitute for workplace change. They use utilization data to identify where support is working and where workload, manager behaviour, staffing, harassment, job design or psychological safety still need attention.

Disability data should not sit outside the benefits review

Disability data is often reviewed separately from health, drug and EAP utilization. That separation can hide important patterns. If extended health claims, mental health claims, paramedical use, short-term disability and long-term disability are all moving in the same direction, HR may be looking at a workforce health issue rather than separate plan-cost issues.

Alberta Blue Cross reported that mental health-related long-term disability claims continued to rise over three years and reached 40% of new approved long-term disability claims in 2025. Its life and disability reporting also notes that more people are presenting with both mental and physical conditions, which can affect how long employees are away from work and what support they need to return safely.

Those findings are important for HR because disability trends are not only insurance trends. They are connected to accommodation, return-to-work planning, manager capability, psychological health and safety, workload, injury prevention and access to care. A disability claim may begin as a medical file, but the employer's response often determines whether the employee returns smoothly, stays connected, relapses, disputes the process or exits the organization.

A mid-year review should ask whether disability claims are increasing, whether claim durations are longer than expected, whether claims are concentrated by department or job family, whether mental health or musculoskeletal conditions are prominent, and whether employees are using early supports before disability claims occur. HR should also review whether managers escalate concerns early enough and whether accommodation files are being managed consistently.

The point is not to scrutinize individual employees. The point is to identify whether the plan, the workplace and the return-to-work process are working together.

Look for underused benefits before changing the plan

Many benefit plans contain value employees do not use. Health spending accounts, wellness spending accounts, virtual care, EAP, second-opinion services, navigation supports, preventative programs, digital mental health tools and paramedical coverage may all be available, but underused because employees do not understand them or do not see them as relevant.

Underutilization can be a communication failure. It can also be an access problem. Lower-paid employees may avoid benefits that require out-of-pocket payment before reimbursement. Shift workers may struggle to book appointments. Employees in rural or remote communities may lack local providers. New employees may be overwhelmed during onboarding and miss plan details. Remote workers may not see posters, lunch-and-learns or informal reminders. Employees may not understand whether dependants are covered.

HR should review underused benefits with the same seriousness as overused benefits. If the employer is paying for a benefit that employees do not use, the fix may be better communication, plan redesign, provider access, manager education or removal of the benefit. The wrong fix is to assume employees do not need it.

A mid-year communication audit should identify which benefits require better explanation. Employees should know what is covered, how reimbursement works, whether family members are eligible, how confidentiality works for EAP or mental health

services, how to access virtual care, how spending accounts work, and when to use disability, accommodation or leave processes.

Equity of access belongs in the review

Benefits utilization can reveal equity problems, but only if HR looks for them carefully. A plan may appear fair because every eligible employee has the same coverage, while practical access differs significantly by role, income level, schedule, location or manager support.

Office employees may use mental health or paramedical benefits more because they have flexible schedules and private time for appointments. Field employees may underuse benefits because the workday is less flexible. Lower-paid employees may avoid services requiring co-pays or reimbursement delays. Employees with disabilities or chronic illness may need more support navigating the plan. Employees in smaller communities may have fewer providers. Employees whose first language is not English or French may not understand the benefit materials well enough to use them confidently.

HR should therefore ask who is not using the plan and why. That does not mean identifying individual claimants. It means looking at patterns, privacy-protective data and employee feedback. If a health spending account is used mostly by higher-paid employees, the issue may be awareness, cash-flow barriers or benefit design. If EAP use is low in one location with known conflict issues, the issue may be trust or communication. If field employees have low paramedical use and high injury absence, access may be the problem.

A benefits plan should support the workforce the employer actually has, not only the workforce most able to navigate benefits on their own.

Privacy and confidentiality must be protected

Benefits utilization reviews involve sensitive information. HR should be clear about what it needs, why it needs it and how employee privacy will be protected. The Office of the Privacy Commissioner of Canada states that employee personal information can include pay and benefit records, attendance reports and personnel files, and that privacy obligations may apply to current, prospective and former employees.

The OPC also emphasizes limiting collection, being transparent, developing clear policies and collecting only personal information necessary for the stated purpose. Employers should consider the sensitivity of the information, whether there is a legitimate business need, whether the collection will be effective and whether less intrusive means could achieve the same purpose.

That guidance matters during benefits review. HR usually does not need individual names, diagnoses, medication details or claim-level information to make plan decisions. In most cases, aggregated reports, trend categories and privacy-protected summaries are enough. If the workforce is small, even aggregate data may be too revealing when divided by department, gender, location or job family.

The review process should be documented. HR should identify who receives the utilization report, whether the data is aggregate or individual, how it will be stored, who may use it, and whether it will be shared with leaders in summarized form only. Benefits data should never be used to speculate about individual employees or manage performance indirectly.

Build the leadership conversation around options

A mid-year review should produce decisions, not just observations. Leadership does not need 40 slides of claims data. It needs a clear explanation of what is changing, what it means, what options exist and what trade-offs are involved.

The leadership briefing should distinguish between three kinds of findings. Some findings are cost-pressure issues, such as rising drug spend or dental fee changes. Some are workforce-risk issues, such as mental health disability trends, musculoskeletal claims or low use of early support. Some are communication or access issues, such as underused EAP, low HSA usage or confusion about virtual care.

For each finding, HR should present practical options. If drug costs are rising, options may include plan management tools, employee communication, biosimilar or generic strategies, special authorization review, better chronic disease support or renewal preparation. If mental health utilization is low but absence is rising, options may include communication, manager training, EAP relaunch, improved counselling coverage or workload review. If disability durations are increasing, options may include earlier accommodation support, return-to-work process improvements, manager training or coordination between the carrier and HR.

This matters because finance may understandably focus on cost. HR should not ignore cost, but it should make sure the conversation also includes retention, wellbeing, productivity, disability prevention, accommodation, employee experience and total rewards competitiveness.

The mid-year benefits review framework

A structured process helps HR turn utilization reports into action. The following framework can be used for most Canadian employer benefit plans, regardless of size, sector or provider.

1. Collect the right data from the insurer, advisor, EAP provider, disability carrier and internal HR systems.
2. Compare year-to-date results with the same period last year, not only with annual budget or renewal projections.
3. Break utilization down by category, including drugs, dental, paramedical, mental health, spending accounts, disability and EAP.
4. Identify the top cost drivers and the fastest-growing categories, then ask whether the drivers are recurring, temporary or concentrated in a small claimant group.
5. Compare benefits data with absenteeism, disability, accommodation, engagement, turnover, safety and workload data.
6. Identify underused benefits that may require better communication, access support or plan redesign.
7. Review equity of access across employee groups, locations, job types, income levels and schedules where privacy rules allow.
8. Protect privacy by using aggregate data, limiting access and avoiding individual speculation.
9. Flag areas likely to create renewal pressure and prepare leadership for trade-off decisions before renewal season.
10. Create a 90-day action plan that includes communication, manager training, plan-design modelling and follow-up metrics.

What HR should avoid

A mid-year benefits review can go wrong when the organization reacts too quickly or too narrowly. HR should avoid cutting coverage based only on a temporary spike. One or two high-cost claims may distort year-to-date experience, especially in smaller plans. HR should understand whether the increase reflects a recurring trend, an unusual event or a broader change in employee need.

HR should also avoid treating high utilization as abuse. Most employees use benefits because they need care. Fraud and misuse should be addressed where evidence exists, but the default assumption should not be suspicion. If the employer communicates benefits changes in a way that sounds punitive, employees may lose trust in the plan.

The organization should not ask for more detailed personal health information than it needs. It should not share sensitive claim information with managers. It should not make benefit changes without explaining the reason. It should not assume employees understand the plan. It should not separate benefits data from absence, disability, safety, retention and engagement data.

Most importantly, HR should not let the entire review become a cost-cutting exercise. Cost sustainability matters, but benefits are also part of the employment value proposition. A plan that becomes cheaper by becoming less useful may create retention, accommodation, morale and health-cost problems later.

The 90-day action plan after the review

The most useful output of a mid-year review is a 90-day action plan. The plan does not need to solve every benefits issue before renewal. It should focus on the few actions most likely to improve understanding, reduce avoidable risk and prepare the employer for better decisions.

A strong 90-day plan may include the following actions:

- Relaunching poorly understood benefits with plain-language examples and employee FAQs.
- Training managers on when to refer employees to EAP, accommodation, disability or leave processes.
- Reviewing drug-plan pressure with the advisor and identifying whether special authorization, generic substitution, biosimilar approaches or other tools need review.
- Auditing disability and return-to-work processes for delays, poor documentation or weak manager involvement.
- Checking whether employees in field, shift, remote or lower-paid roles face access barriers.
- Preparing renewal scenarios for leadership that show cost, employee impact and risk trade-offs.
- Reviewing benefit communication during onboarding and at key points in the employee lifecycle.
- Creating a short pulse survey to test whether employees understand the benefits they already have.

If the review identifies plan-design concerns, HR should also work with the benefits advisor to model options before renewal. That might include changes to maximums, health spending account structure, drug-plan management, mental health coverage, virtual care, co-insurance, eligibility rules or employee communication. The point is to create time for thoughtful choices rather than renewal pressure.

The HR takeaway

A mid-year benefits utilization review should not end with the statement, ‘Claims are up.’ That is not enough. HR needs to know why claims are moving, what employee needs are changing, where the plan is underused, where it is overextended and what the organization should do before renewal.

The best reviews connect benefits data to workforce reality. Prescription drug trends may reveal chronic disease and specialty drug pressure. Mental health utilization may reveal early support or deeper strain. Disability claims may reveal return-to-work gaps. Low EAP usage may reveal a trust or awareness problem. Health spending account patterns may reveal equity or access barriers. Rising dental or paramedical claims may reflect both cost pressure and employees trying to maintain health.

Canadian HR professionals do not need to become actuaries, pharmacists or clinicians. They do need to ask better questions. They need to protect privacy, interpret utilization in context, connect claims data to employee experience, brief leadership with options and take action before renewal becomes a scramble.

Benefits utilization data tells a story. Mid-year is when HR still has time to change how that story ends.