TLCx

Beyond the AEP Surge: Designing Medicare Advantage Around the Member

A leadership perspective on turning predictable enrollment pressure into better member experience, stronger operating performance, and sustainable quality

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Executive Summary

Every year, Medicare Advantage organizations enter a period of predictable operational intensity.

The Annual Enrollment Period (AEP) brings increased enrollment activity, benefit questions, coverage decisions, provider and pharmacy inquiries, and greater demand for member support. Beginning January 1, the Medicare Advantage Open Enrollment Period (OEP) creates another important window as members evaluate whether the coverage they selected is meeting their needs.

None of this is unexpected.

Yet across the industry, seasonal pressure can still translate into longer waits, repeat contacts, escalations, member complaints, inconsistent answers, and frustration at precisely the moment members most need clarity.

The opportunity for Medicare Advantage leaders is to change the premise.

> **IN PLAIN TERMS**
> "AEP and OEP are predictable. Member confusion may be understandable. Poor member experience should not be inevitable."

The strongest organizations will increasingly treat these periods not simply as contact-volume events, but as enterprise-wide tests of how effectively the health plan anticipates member needs, scales capacity, resolves issues, communicates complexity, learns from friction, and connects service delivery to the broader mission of care.

This matters beyond traditional contact-center performance. CMS continues to emphasize quality, outcomes, access and patient experience within Medicare Advantage. For 2027, CMS is streamlining the Star Ratings measure set specifically to increase focus on areas where meaningful performance differences exist, including clinical care, outcomes and patient experience.

For health plans, the implication is significant: operational experience and healthcare quality cannot be managed as entirely separate disciplines.

The member does not experience them separately.

The Annual Surge Should Be Treated as a Known Operating Condition

KEY DATES

- AEP — October 15 through December 7: beneficiaries can change Medicare Advantage and prescription drug coverage for the following year.
- OEP — January 1 through March 31: members already enrolled in Medicare Advantage can change plans or return to Original Medicare.

Medicare's Annual Enrollment Period occurs every year from October 15 through December 7. During that window, beneficiaries can make changes to Medicare Advantage and prescription drug coverage for the following year.

Plans themselves may also change from year to year, including costs, coverage, provider networks and pharmacy networks, which is why Medicare encourages beneficiaries to review their Evidence of Coverage and Annual Notice of Change.

The resulting questions should therefore surprise no one.

Members want to know whether their physician remains in network. They may need help understanding prescription coverage, premiums, copayments or supplemental benefits. Some will be comparing plans. Others may simply be trying to understand what changed.

Then January arrives.

For members already enrolled in Medicare Advantage, the Medicare Advantage Open Enrollment Period runs from January 1 through March 31, providing another opportunity to change Medicare Advantage plans or return to Original Medicare.

Operationally, these periods create pressure.

But predictability changes the leadership question.

The question should not simply be: how do we handle the additional volume?

It should be: what should we design differently because we know the additional demand, and the reasons behind it, are coming?

That distinction matters.

Forecasting, staffing and scheduling remain essential. But an effective AEP/OEP operating model must extend beyond workforce mathematics. It should anticipate why members will contact the plan, what information agents will require, where complexity is likely to create confusion, which interactions are most likely to escalate, where language needs will emerge, and what happens when forecasts are wrong.

Capacity is necessary. Preparedness is broader.

The Contact Center Is Part of the Healthcare Experience

Healthcare organizations have traditionally separated clinical care from administrative service. Members rarely make that distinction.

Consider the nature of the questions entering a Medicare Advantage contact center. Is my physician still covered? Why did my prescription cost change? What does this letter mean? How do I access this benefit? Where can I receive care? Why was something denied? Who can help me understand what happens next?

The agent answering those questions may not be providing clinical care. But the interaction can materially affect a member's ability to navigate the healthcare system.

That changes how leaders should think about service metrics.

First-call resolution is not simply an efficiency measure when the alternative is asking an older adult to repeatedly navigate a complicated system. Language accessibility is not simply a staffing consideration when comprehension determines whether a member understands the answer. Quality assurance is not merely a compliance exercise when inaccurate information can influence healthcare decisions. Escalation management is not simply a workflow when the member on the other end may already be frustrated, vulnerable or uncertain about accessing care. And empathy is not merely a soft skill when the person calling may be dealing simultaneously with health concerns and administrative complexity.

The contact center therefore deserves to be viewed as part of the broader member-care ecosystem.

Resolution Should Matter as Much as Responsiveness

For decades, contact centers have been optimized around accessibility and efficiency: service level, average speed of answer, average handle time and cost per contact.

Those measures remain important. Members should not have to wait unnecessarily for assistance.

But optimizing exclusively around speed can produce the wrong behavior. Consider, for example, a longer interaction that fully resolves a complicated issue: it may create considerably more value than a shorter interaction that generates a second call, an escalation or a complaint.

Medicare Advantage organizations should therefore consider a broader hierarchy of performance during enrollment periods:

THE HIERARCHY OF PERFORMANCE

- Can the member reach us?
- Can we understand what the member actually needs?
- Can we provide an accurate answer?
- Can we resolve the issue as completely as possible?
- Does the member understand what happens next?
- Did we eliminate the reason for another contact?

This shifts management attention from handling contacts toward resolving member needs.

It also changes the role of quality assurance. Rather than primarily identifying whether an agent followed a prescribed process, modern QA should help identify why contacts fail. Was information difficult to locate? Was the policy unclear? Did systems provide conflicting information? Was there a knowledge gap? Did the member misunderstand the explanation? Was a language barrier involved? Did the workflow require an unnecessary transfer?

Those findings should not remain inside the contact center. They should feed operations, training, digital experience, product, provider operations and plan leadership.

Complaints Are More Than a Score, They Are Intelligence

No health plan wants member complaints. But an organization focused exclusively on reducing the complaint count risks overlooking their greater value.

Complaints identify friction. So do repeat contacts, transfers, escalations, low satisfaction scores, failed self-service attempts and unusual spikes in particular call drivers. Together, these signals can create an early-warning system for member experience.

During AEP and OEP, that intelligence becomes particularly valuable because the concentration of activity can expose weaknesses quickly.

If hundreds of members are asking the same question, the problem may not be the members. If agents repeatedly struggle to explain a benefit, the problem may not be agent performance. If one issue generates disproportionate transfers, the workflow may need redesign. If members repeatedly contact the plan after using a digital channel, the digital experience may not actually be resolving their needs. If particular language populations experience higher escalation or repeat-contact rates, accessibility may require additional attention.

The objective should therefore move beyond handling each complaint individually toward identifying the operating condition that created it. A mature member-experience organization continually asks: what is the system trying to tell us?

Star Ratings Should Be an Outcome, Not the Only Objective

Quality measurement inevitably influences organizational priorities. That is appropriate.

CMS Star Ratings help beneficiaries compare plan quality and also influence Quality Bonus Payments and rebates for Medicare Advantage contracts. The current framework evaluates plans across outcomes, intermediate outcomes, process, patient experience and access.

CMS is also evolving the framework. Changes finalized for 2027 streamline the measure set and place greater focus on clinical care, outcomes and patient experience where meaningful performance differences exist.

That direction reinforces an important leadership principle.

Plans should certainly understand the measures and manage performance rigorously. But the most durable strategy is not simply to optimize individual metrics.

> **THE PRINCIPLE**
> "Design the experience around the member, and allow the measures to reflect the result."

- Reduce confusion because members deserve clarity.
- Improve resolution because members should not need multiple attempts to obtain an answer.
- Strengthen language access because comprehension matters.
- Analyze complaints because they reveal where the experience is failing.
- Improve coordination because members experience the health plan as one organization, regardless of how many internal departments participate in resolving their issue.

When those things improve, many of the measures regulators and health plans care about should move in the same direction.

The distinction is subtle but important. One approach manages the score. The other manages the experience that creates the score.

A Different Operating Model: Anticipate. Resolve. Learn.

Preparing for AEP and OEP requires hundreds of operational decisions. But they can be organized around three leadership imperatives.

THE FRAMEWORK

- Anticipate — know why members will call before they call.
- Resolve — give the frontline what it needs to close the issue on contact.
- Learn — turn every interaction into intelligence that changes operations.

1. Anticipate

Use historical demand, enrollment projections, benefit changes, call-driver analysis and member demographics to anticipate not only how many contacts will arrive, but why.

Capacity planning should include credible surge scenarios rather than relying solely on the base forecast. Workforce design should consider extended hours, weekends, language requirements and remote talent pools. Knowledge management should identify the benefits and policy changes most likely to generate questions before calls begin. Training should emphasize complex scenarios, not simply process adherence. Technology should make the correct answer easier for agents and members to find.

And contingency plans should answer a simple question before the season begins: what will we do if our forecast is wrong?

2. Resolve

Once the member makes contact, resolution becomes the priority.

That means giving frontline teams the knowledge, authority, tools and escalation pathways required to solve problems. Organizations should examine first-call resolution alongside handle time rather than allowing efficiency targets to unintentionally encourage incomplete interactions. Quality programs should measure accuracy and comprehension, not simply script adherence. Language support should be designed around actual member demographics and demand patterns. Escalation paths should be clear and fast.

And when an issue cannot be resolved immediately, the member should understand who owns it and what happens next.

3. Learn

AEP and OEP generate an enormous amount of member intelligence. Organizations should capture it.

Call reasons, complaints, repeat contacts, escalations, sentiment, quality findings and digital failures should be analyzed together. Patterns should be surfaced rapidly enough to change operations during the enrollment period, not merely documented afterward.

Leaders should ask which issues could be eliminated entirely. The highest-performing contact is not necessarily the one handled most efficiently. Sometimes it is the contact the organization prevents from becoming necessary.

Technology Can Amplify the Model, but It Cannot Substitute for One

Artificial intelligence creates significant opportunities in this environment.

AI-enabled knowledge management can help agents locate information more quickly. Automated quality tools can expand the percentage of interactions reviewed. Analytics can identify emerging call drivers and sentiment patterns. Agent-assist capabilities can reduce cognitive load. Digital tools can resolve straightforward questions without requiring a live interaction.

But technology alone will not solve a poorly designed member journey. Automating confusing processes simply creates faster confusion.

The starting point should therefore be the member need and the operating outcome. Where is friction occurring, and why? Which problems should be prevented? Which require human judgment? Which can be automated safely? Where does an agent need better information? Where does the organization need better intelligence?

Technology becomes powerful when deployed against those questions.

The Leadership Opportunity

AEP and OEP will continue to test Medicare Advantage organizations. Demand will move. Forecasts will sometimes miss. Benefit changes will generate questions. Members will occasionally be confused. And operations will experience pressure.

The goal cannot be to eliminate every variable. It should be to build an organization capable of responding to those variables without allowing predictable pressure to become an acceptable explanation for an avoidable member experience.

That requires more than additional agents. It requires integrated workforce planning, strong training, effective knowledge management, language accessibility, disciplined quality assurance, intelligent escalation, actionable analytics, resilient technology and governance capable of turning member feedback into operational change.

Most importantly, it requires remembering what all of those capabilities are designed to accomplish.

> **CLOSING REFLECTION**
> "Behind every service level is a person waiting. Behind every repeat contact is a problem that may not have been resolved. Behind every complaint is an experience worth understanding. Behind every Star measure are individual members whose experiences ultimately create the result."

AEP and OEP are predictable. The opportunity is to make clarity, resolution and confidence equally predictable for the member.