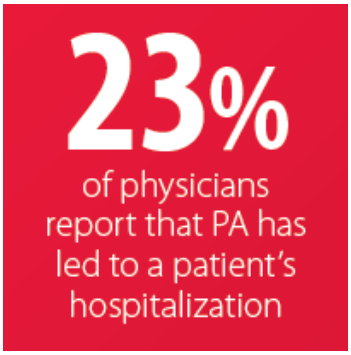
American Urological Association

2026 Annual Urology Advocacy Summit

REFORM PRIOR AUTHORIZATION

ISSUE



Prior authorization is a health insurance utilization management tool that requires health care professionals to obtain advance approval from the plan before a prescription medication or medical service qualifies for payment and can be delivered to the patient. The process of obtaining approval from insurance companies is often lengthy and can lead to significant delays in providing necessary care. Physicians typically spend two or more days a week negotiating with insurance companies for prior authorizations, which can exacerbate administrative burdens and physician burnout. Prior authorization protocols are particularly common in Medicare Advantage (MA) and while they may be appropriate in some situations, evidence suggests they've been overly deployed and indiscriminately applied. In 2022, the HHS Office of Inspector General found that MA plans use prior authorizations to deny medically necessary care that meets coverage requirements under traditional Medicare and is supported by the enrollee's medical records.

Alarmingly, the Centers for Medicare & Medicaid Services (CMS) recently introduced prior authorization requirements to traditional Medicare for the first time ever with the launch of the Wasteful and Inappropriate Service Reduction – or WISeR – model. The program went into effect earlier this year in six states – Arizona, New Jersey, Ohio, Oklahoma, Texas, and Washington – and applies to several services, including those to treat common urological conditions like urinary incontinence and erectile dysfunction. Concerningly, CMS plans to contract with private firms to use artificial intelligence to assess whether patients qualify for coverage for applicable services and procedures. Notably, comparable algorithms already in use by insurers have drawn legal challenges, with lawsuits alleging that the technology enabled companies to rapidly deny large numbers of claims, restricting patient access to the care they need and negatively impacting patient outcomes.

THE ASKS

- **Cosponsor The Improving Seniors' Timely Access to Care Act (S. 1816/H.R. 3514)**, which imposes new transparency requirements to shore up prior authorization practices in Medicare Advantage plans. The bill codifies regulatory changes previously enacted in 2024 and reflects similar legislation that passed the House of Representatives unanimously by voice vote during the 117th Congress. The AUA, along with more than 230 national and state organizations from across the medical community, supports the legislation.

- **Cosponsor *The Seniors Deserve SMARTER (Streamlined Medical Approvals for Timely, Efficient Recovery) Care Act* (S.3484/ H.R.5940)**, which prohibits CMS from implementing the

WISeR model or any similar model in traditional Medicare, thereby preserving and protecting timely access to care for enrollees.

CONTACT

To cosponsor ***The Improving Seniors' Timely Access to Care Act***, please contact Alex.Sells@mail.house.gov with Rep. Mike Kelly (R-PA-16) and Max_Seltzer@marshall.senate.gov with Sen. Roger Marshall, MD (R-KS).

To cosponsor ***The SMARTER Act***, please contact Mariah.Baker@mail.house.gov with Rep. Suzan Delbene (D-WA-1) and Shauna.Rust@murray.senate.gov with Sen. Patty Murray (D-WA).