American Society of Echocardiography

2026 American Medical Association Annual House of Delegates Meeting Summary

This is a brief summary of the 2026 annual AMA HOD meeting June 6 to June 10, 2026, in Chicago, IL. This report was written by ASE Delegate, Kamu Maganti, MD, FASE.

The 2026 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD) was held in Chicago, Illinois, from June 6–10, 2026. Approximately 80% of the House's 729 delegates were present. There was a lot of excitement overall but with significant security oversight.

The meeting was characterized by robust discussion surrounding anti-obesity medications, healthy diets, artificial intelligence, transparency regarding AMA's performance, maintenance of certification, and healthcare system transparency.

ASE was represented by Dr. Peter Rahko and myself as delegates, with invaluable support from Katherine Stark, ASE Director of Advocacy. Participation in the AMA HOD continues to provide ASE with an important voice in national physician policy discussions and preserves the Society's direct access to organized medicine, including its participation in subspecialty caucuses and interactions with the AMA Relative Value Scale Update Committee (RUC) process.

This meeting is organized first into caucuses which are made up by organ system from subspecialty societies and the other half of delegates are from state associations. ASE currently has two delegates (Dr Rahko and I) which allows us considerable latitude in leveraging in the services of AMA on many topics that you are well aware of.

At the assembly, there is first the collection of resolutions that may be sent in by any delegate from either state associations or subspecialty societies for consideration. The reference committees' function much like congressional hearings, where each resolution is presented by its advocate to a committee and anybody who is attending the hearings can stand up and comment upon. Controversial topics take long periods discussion. These resolutions are then worked through by the reference committee and are recommended for adoption or not adoption or are rewritten, revised, or consolidated with multiple resolutions. The reference committees also hear reports from various societies of the AMA, usually on topics that were reports from previous meetings.

The cardiovascular medicine caucus gives us an opportunity to directly meet with delegates from ACC, other subspecialties societies such as SCAI, ASNC, HRS, SCCT, SCMR etc. This gives us a good cross section of how other organizations are viewing these issues. There is also a subspecialties service (SSS) caucus which encompasses all subspecialty societies that meets multiple times throughout the meetings, and they give you another cross-sectional flavor as to what other subspecialties societies are interested in and concerned about. Dr Rahko and I attended these meetings as delegates of the house. While relatively few resolutions directly affected cardiovascular imaging, several actions taken during this meeting have important implications for echocardiography, cardiovascular imaging, artificial

intelligence, physician certification, and Medicare reimbursement. The most relevant developments are summarized below.

<u>Monday, 6/8/26 and Tuesday, 6/10/26:</u>

Meeting of reference committees as follows:

- Reference Committee on Amendments to Ethics & Bylaws, which covers the **AMA constitution, bylaws and medical ethics matters**
- Reference Committee A, which covers **medical service**
- Reference Committee B, which covers **legislation**
- Reference Committee C, which covers **medical education**
- Reference Committee D, which covers **public health**
- Reference Committee E, which covers **science and technology**
- Reference Committee F, which covers **AMA governance and finance**
- Reference Committee G, which covers **medical practice**

 # Reference Committee on Amendments to AMA Constitution, Bylaws and Medical Ethics:

Resolution 013 was adopted. It dealt with evidence-based artificial intelligence (AI) tools that can strengthen collaboration with non-physician clinicians through improved interdisciplinary communication, decision support, and workflow as well as direct the AMA to support the development and dissemination of best practices for AI integration into physician-led care teams, with emphasis on safety monitoring, transparency, cyber hygiene, and preserving physician leadership in clinical decision-making. In addition, encouraging further research on AI interventions that demonstrate how AI can enhance physician-led team effectiveness, reduce misalignment of clinical risk perception, and improve coordination of care.

Resolution 007 dealt with federal regulation of AI scribe technologies that protects clinician and patient privacy by mandating informed consent, opt-in for secondary use, data minimization, and federal vendor accountability. Further, this directed AMA pursue federal regulation of artificial intelligence (AI) scribe technologies that protects clinician and patient privacy.

Resolution 010 supports sponsoring institutions providing access to financially-supported transportation assistance and other appropriate fatigue-mitigation resources for trainee physicians following extended duty periods when fatigue may impair safe travel, with consideration given to local resource availability, geographic constraints, and institutional capacity.

The HOD also advocated for and support state and federal legislation or regulation that ensures local practicing physicians direct and control the development and implementation of patient scheduling protocols, workload standards, patient panel limits and clinical staffing models within their practices and health systems, based on clinical complexity, time required for direct and indirect care, and safe practice standards rather than productivity or revenue targets.

Reference Committee F

BOT report # 4 recommends no change to the dues levels for 2027

Regular Members $420

Physicians in Their Fourth Year of Practice $315

Physicians in Their Third year of Practice $210

Physicians in Their Second Year of Practice $105

Physicians in Their First Year of Practice $60

Physicians in Military Service $280

Semi-Retired Physicians $210

Fully Retired Physicians $84

Physicians in Residency/Fellow Training $45

Medical Students $20

Resolution 610 encourages the use of evidence-based behavioral science strategies, such as choice architecture and nudging, to promote healthier dietary choices at professional gatherings, while respecting individual autonomy. It further recognizes the importance of modeling prevention through food choices at its own meetings, with an emphasis on increasing the plant-based food choice options which also contain minimal contributions from animal products, as an exemplary method for the promotion of individual and planetary health.

Resolution 618 was referred. It directs that AMA divest from all companies that derive a majority of their revenue from the manufacturing of weapons, cluster munitions, chemical, biological, or nuclear weapons, or key component of these weapons and asked that AMA report back to the House of Delegates on what progress has been made towards divestment.

Reference Committee A:

Resolution 105 discussed that AMA oppose efforts to force Medicare recipients to be auto enrolled into Medicare Advantage plans, thus making Medicare Advantage plans the default option.

Resolution 108 seeks meaningful and transparent involvement of physicians who could potentially be participants in Center for Medicare and Medicaid Innovation (CMMI) models throughout the model development process, prior to approval for testing or implementation. The testimony was very much in support as it would mitigate issues.

Reference Committee G:

Resolution 703 actively opposes preferential pricing strategies by pharmaceutical manufacturers that offer discounted medications exclusively to telehealth or online providers, as such practices undermine the established physician-patient relationship and the continuity of care.

Reference Committee E:

CSAPH Report 07 was adopted. This deals with the framework to convey evidence-based medicine in AI tools used in clinical decision making.

It specifically asked to recognize and promote the importance of transparency and explainability of AI tools used in clinical decision support to ensure the quality of medical evidence and the grading of medical evidence including the sources are clearly conveyed to physicians so clinical recommendations and outputs can be accurately verified and validated as tools to assist physicians in making clinical decisions. Also, to collaborate with medical specialty societies, relevant key parties, regulators, and AI developers to establish standards and develop a framework for evidence attribution, evaluation, and validation in AI clinical decision support systems. In addition, to encourage medical education key parties to incorporate training on the utility, limitations and interpretation of evidence-based medicine practices when using AI tools in clinical decision- making. Lastly, to monitor best practices and policies of AI transparency and evidence-based recommendations to improve the quality and reliability of patient care.

Resolution 507 asked AMA to support, publicize, and advocate for the concomitant use of evidence-based, structured lifestyle and behavioral intervention programs, delivered with ongoing clinician and care-team support, in conjunction with the prescribed use of glucagon-like peptide-1 receptor agonists for obesity and other related, preventable disease states and illnesses; recognize and address potential health disparities associated with recommendations for structured lifestyle intervention programs accompanying glucagon-like peptide-1 receptor agonist's therapy, and advocate for equitable access to evidence-based, clinician-supported lifestyle interventions across diverse care settings, including community-based, digital, hybrid, and safety-net models of care; and advocate for coverage, reimbursement, and sustainable payment models that support the delivery of clinician-led, therapeutic, and structured lifestyle intervention programs as a component of glucagon-like peptide-1 receptor agonist and other anti-obesity medication therapy, particularly for underserved, rural, and historically marginalized populations, to mitigate disparities in access and outcomes, provided that coverage of these medications shall not be conditioned upon participation in such lifestyle intervention programs.

Reference Committee C:

Resolution 302 discusses the excessive cost of multi-state DEA licensure. It recommends AMA continue its support of person-specific rather than site-specific Drug Enforcement Administration (DEA) registration numbers and a one-time DEA registration fee by reaffirming existing AMA policies,"One Fee One Number D-100.975" and "One Fee, One Number D-100.980."

Resolution 316 is reaffirmed, and deals with reassessment of continuing board certification process. American Medical Association was asked to undertake a thorough review and analysis of the available literature, data, and evidence to re-examine and update the accepted standards for continuing board certification including policy, Specialty Board Certification Standards, so the standards reflect the best manner to assess physicians' knowledge and skills necessary to practice medicine.

Reference Committee D:

BOT report 17 supports additional research efforts to establish pathological Blood Pressure variability thresholds to guide dietary and exercise recommendations, sleep evaluation, risk stratification, and other evidence-based interventions by healthcare providers; and the integration of blood pressure

variability data into electronic medical records, emphasizing automated calculation capabilities similar to those established for body mass index once additional research has been published on this topic, including peer-reviewed evidence establishing clinical utility, reproducibility of blood pressure variability metrics, and such research has informed recommendations or guidance from relevant clinical and public health authorities.

CSAPH report 3 supports removal of BMI as a standard measure in medicine and recognizing a culturally-diverse and varied presentations of eating disorders. It was felt that the issues with using BMI as a measurement because: (a) of the historical harm of BMI, (b) of the use of BMI for racist exclusion, and (c) BMI cutoffs are based primarily on data collected from previous generations of non-Hispanic White 28 populations and does not consider a person's gender or ethnicity. There is significant limitations associated with the widespread use of BMI in clinical settings and suggests its use be in a conjunction with other valid measures of risk such as, but not limited to, measurements of: visceral fat, body adiposity index, body composition, relative fat mass, waist circumference and genetic/metabolic factors. It is felt that BMI is significantly correlated with the amount of fat mass in the general population but loses predictability when applied on the individual level that relative body shape and composition heterogeneity across race/ethnic groups, sexes, and age-span is essential to consider when applying BMI as a measure of adiposity. It was also felt that the use of BMI should not be used as a sole criterion to deny appropriate insurance reimbursement. BMI should be evaluated within the context of comorbidities, baseline mortality risk, and environmental factors such as chronic stressors, poor nutrition, and low physical activity may be used for risk stratification. BMI is a widely used tool for population level surveillance of obesity trends due to its ease of use and low risk for application inconstancies, but BMI does not fully capture the complexity of the obesity epidemic. In addition, BMI, in combination with other anthropometric measures and environmental factors, may be useful as an initial screener to identify individuals for further investigation of metabolic health risks.

Resolution 430 deals with supporting the inclusion of information about lung cancer screening within cigarette packages. AMA was also directed to work with appropriate public health organizations and governmental agencies to monitor the impact of "non-combustible tobacco" nicotine delivery devices on cancer epidemiology and promote appropriate cancer screening.

 # Reference Committee B:

BOT report 25 recommends federal legislation to prohibit the corporate practice of medicine in order to protect physician autonomy and strengthen the physician-patient relationship, support federal legislation prohibiting lay entities, including but not limited to insurance companies, private equity firms, non-physician individual licensed health care professionals and other non-physician-owned entities or individuals, from interfering with, controlling, or otherwise directing 1) the independent professional judgment or clinical decisions of a physician, or 2) the operational authority of physicians within their practices, provided that any such legislation include a specific saving clause clarifying an intent to preserve the right of states to enact and enforce more stringent state laws. Also, AMA was asked to support whistleblower programs that allow individuals to report knowledge of violations of a law prohibiting lay entities from interfering with, controlling, or otherwise directing the professional judgment, clinical decisions, or operational authority of a physician to the appropriate enforcement agency. In addition, AMA was asked to support the implementation and enforcement of strong state laws or regulations that prohibit the corporate practice of medicine.

Resolution 249 supports bringing physician' voices to the implementation if AI prescribers. It recommends that autonomous clinical artificial/augmented intelligence (AI) including AI prescription services, be regulated and licensed by an appropriate body, as well as be developed with physician input and operated under direct physician supervision.

Resolution 223 deals with ensuring due process, transparency, human clinical oversight in the use of AI for health insurance coverage and eligibility determinations. AMA has been directed to oppose the use of artificial intelligence, algorithms, or automated decision-making systems as the sole basis for any adverse health insurance determination, including denials, delays, or of coverage and adverse eligibility, underwriting, or enrollment determinations affecting health insurance applicants or insured patients; when artificial intelligence or automated decision-making systems are used in adverse health insurance determinations, any required human review must be conducted through the independent judgment of a licensed physician in accordance with existing AMA peer review policy, and must not be overridden, dictated, or unduly influenced by the output of such systems and lastly, to advocate for policies requiring that patients and physicians be provided a clear and accessible explanation when artificial intelligence or automated decision-making systems materially contributed to an adverse health insurance; support and advocate for payer-specific regulatory standards governing the use of artificial intelligence and automated decision-making systems in adverse health insurance determinations, including requirements for auditable records of AI-assisted decisions, independent validation, regular testing for accuracy, bias, and clinical validity, and oversight by appropriate regulatory bodies, and lastly advocate for the uniform application of safeguards governing artificial intelligence and automated decision-making systems across all payer types and markets, including commercial insurance, individual and small-group markets, employer-sponsored coverage, and government insurance, with particular attention to applicant-facing eligibility, underwriting, and enrollment decisions. This was referred for further study.

In summary, there was a huge volume of resolutions presented and discussed in great detail, but the vast majority of them did not have direct impact on ASE, or on cardiovascular disease or medical imaging. We will be following some of the referred resolutions intently at the interim AMA 2026 meeting, and will provide updates accordingly.

Again, it was our pleasure to serve ASE by attending the 2026 annual AMA meeting.
Please feel free to contact us if you have questions or need additional information. Katherine Stark has all of the details if you so desire to explore any of these substantial reports or resolutions.

Sincerely,

Kamu Maganti, MD, FASE
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