jiro

INDUSTRY ANALYSIS

Women's health · Reimbursement

Anatomy of a payment gap

Medicare and commercial reimbursement for matched male- and female-anatomy procedures. 2025 analysis with 2023 baseline and 2026 outlook.

14%

Less paid by Medicare for the female-anatomy procedure, in the median of 55 matched pairs

107 vs 84

Operating minutes Medicare credits, male against female

$167

Commercial dollar gap per procedure in claims, against $124 under Medicare

Jiro Health

November 2026

EXECUTIVE SUMMARY

Why reimbursement belongs in the women's health conversation

What a procedure reimburses is one of the clearest signals of what the health system values. A 2025 study in the Journal of Women's Health found that Medicare assigns lower work values to many procedures on female anatomy than to their counterparts on male anatomy (Penn et al., 2025). The American College of Obstetricians and Gynecologists has said that the bundled payment codes for maternity care no longer reflect the care being delivered (ACOG Statement of Policy, 2024). Both raise the same question: what do these payment patterns mean for women's health care?

This report answers one part of that question. We repeated the Penn study on the 2025 Medicare fee schedule, and then asked whether commercial insurers, whose contracted rates and claims we also examined, show the same pattern. The 2026 fee schedule is covered separately in Section 3. We compare Medicare fee-schedule amounts, published commercial rates, and allowed amounts on claims. We are not explaining why the differences exist, and we are not measuring their effect on physician earnings, hospital resources, access to care or patient outcomes.

This report does not cover the pay of women surgeons, how hospitals fund women's health services, or clinical outcomes. Those are about the clinician or the service rather than the price Medicare sets for a procedure code.

What we did

Penn et al. took 55 pairs of surgical procedures, each pairing an operation on male anatomy with its closest counterpart on female anatomy, and compared what Medicare paid for each side in 2023. They found the female-anatomy procedures paid less. We first confirmed that our method reproduces their five headline dollar figures to the cent. We then ran the same comparison on the 2025 fee schedule, on commercial insurers' contracted rates, and on the amounts allowed on 2025 claims, which the original study could not do.

Terms used throughout

Payment is the amount Medicare allows for a procedure code, not what a clinician earns.

The gap is the male-anatomy payment minus the female-anatomy payment within each pair, averaged across the pairs.

Facility means a hospital or surgery center; **office** means a physician's office. We use the facility rate because most of these procedures are done there.

RVUs price each code in points for the surgeon's work, practice costs and malpractice insurance. Points × the **conversion factor** = payment.

A **p-value** below 0.05 is conventionally treated as statistically significant; it is not the probability that a result arose by chance.

What we found

01 **We reproduced the study's headline figures.** We rebuilt the 2025 Journal of Women's Health analysis from the same Medicare files and matched its five headline figures to the cent, including the $75.73 average gap between a procedure on male anatomy and its counterpart on female anatomy. Then we ran the same method on 2025 data, and checked each of the study's 55 pairs against CMS's own code descriptions.

02 **The gap has grown.** Across the 54 pairs we can follow every year, the average Medicare payment gap went from $75.92 in 2023 to $80.29 in 2025, up 5.7%. That is not inflation lifting two unequal numbers. Medicare did not change the value it puts on the surgeon's work for a single one of these codes. What moved was the allowance for practice costs, and the gap in points moved toward the male-anatomy procedure in 51 of the 55 pairs. The increase in the average holds after removing every pair that has been questioned, including 15 we now flag ourselves; the median is flat once all 15 are removed.

03 **Medicare assigns the two sides different minutes; no significant difference per assigned minute was detected.** Priced per minute of the operating time CMS assigns, the two sides come out close: $7.28 for the male-anatomy procedure and $7.88 for the female, a difference that could be chance. The dollar gap tracks the minutes Medicare credits, 107 for the male procedure against 84, and how often it classes a procedure as minor: 33% of the female-anatomy codes (plus 5% that are add-on codes) against 12% of the male-anatomy codes. Whether those minute counts are right is the open question. They come from surveys in which surgeons estimate their own operating times, and when RAND checked 711 codes against recorded times in 2025, about half were overstated and one in nine understated.

04 **In 2026 the dollar gap shrinks, but only because everything was cut.** The average gap falls from $80.29 to $63.18. The gap narrowed while payments fell on both sides. Medicare cut every one of the 92 codes in these pairs that year and raised none. The male-side procedures are priced higher, so the same percentage cut takes more dollars off them, and the gap closes on paper. As a share of what Medicare pays, the relative gap narrowed only modestly, from 25.9% to 24.8%. Women's procedures actually took the bigger cut on practice costs (−28.2% against −25.4%).

05 **The observed commercial claims show a similar relative gap and a larger dollar gap.** In allowed amounts observed in claims, the commercial gap is 39.1% against Medicare's 39.3%, about the same in relative terms. Because commercial pays more overall, the dollar gap in claims is larger: $167 per procedure against $124.

06 **Published insurer rates run well above what claims data show being allowed.** For a single procedure, the 90th percentile of contracted rates in the May 2026 price files is roughly 8.5 times the 10th. The median amount allowed on 2025 commercial claims sits near the bottom of that range, around the 25th percentile, and below the posted median on 100% of the 60 codes we could compare.

What readers should take away

Keep the size of the gap and the trend separate

The size of the gap is mostly a story about the 17 pairs that Medicare classifies differently on the two sides (15 major against minor, 2 involving add-on codes). The growth in the gap is a different story: it shows up in the evenly matched pairs too, and more strongly there.

Treat reimbursement as a signal, not a patient outcome

Lower payment may affect whether a service can be sustained, but this report does not measure hospital resources, staffing, operating-room access, training, waiting times or outcomes. Those are questions for follow-on work.

Commercial shows the gap persists, not why

In the claims we observed, the relative gap under commercial insurance is about the same as under Medicare and the dollar gap is larger. The data show that it persists. They do not show why.

Look at what was allowed, not only what was posted

Posted insurer rates and allowed amounts on claims are different things, and the gap between them is large. Compare actual payments by payer and by setting before relying on a price file.

Reading the charts Male-anatomy procedure · Female-anatomy procedure · Gap between the pair

01 We reproduced the study's headline figures

Penn et al. used the 2023 Medicare Physician Fee Schedule and 55 matched pairs of procedures. Rebuilding their method from the same files gives their published results exactly:

Published figure	Penn et al. (2025)	This replication
Pairs with lower female work RVU	41 / 55 (75%)	**41 / 55 (75%)**
Pairs with higher male facility payment	35 / 55 (64%)	**35 / 55 (64%)**
Mean facility payment difference	$75.73	**$75.73**
Mean nonfacility payment difference	$31.98	**$31.98**
Mean facility percent difference	25.6%	**25.6%**

We also checked the fee-schedule data against the official CMS file for 2026 and found no mismatches across the 92 study codes. An independent audit re-derived every figure above from a fresh download of the CMS files and reached the same numbers. One published figure does not reproduce exactly: the study's "30% higher" work-value headline comes out at 32.7% on the same formula and the same 55 pairs.

Three things the source study does not say

Reproducing a number is not the same as endorsing it. Three points about the published headline deserve to be stated.

1. The $75.73 facility gap is not statistically significant when tested pair by pair (p = 0.088). The 95% confidence range runs from −$11.62 to +$163.07 and includes zero. The middle pair's gap is $65.40, and the spread across pairs is wide (standard deviation $323.10).
2. The $31.98 office-setting figure is not a typical case. The middle pair's gap is $86.07, higher than the average, because a few large negative pairs pull the average down (p = 0.53).
3. The 55 pairs use only 93 distinct codes, not the 110 the paper states. CPT 56740 (Bartholin's gland) appears in four pairs, 58285 in three, and 13 other codes twice, and one pair bills two codes on the male side (54530 with 38770). They are not 55 independent observations, so any test that treats them that way is generous.

None of this changes the direction of their finding, and none of it affects our own headline, which is about the trend rather than the size of the gap. Section 2 shows that the average gap is larger in 2025 under every exclusion we tried. One further caveat applies to the nonfacility (office) figures: CMS marks 76 of the 93 study codes as rarely or never performed in an office, which touches 47 of the 55 pairs. The nonfacility figures are kept for replication, not as a measure of office reimbursement.

COUNTERPOINT

The evidence on the other side

One published study reports a different result, and a specialist audience will raise it. Hathaway et al. (Urology Practice, July 2024) report the joint review by the American Urological Association and ACOG. Representatives of both societies went through the full code set for sex-specific procedures with a counterpart on the other sex, then compared them using the AMA committee's own method, matching also on major-or-minor classification, operating time, total time, hospital days, follow-up visits and the date the committee reviewed each code. Penn et al. describe this review as unpublished; it appeared in print in July 2024, seven months before their paper went online in February 2025 and ten months before its print issue.

It found no statistically significant work-value difference among 10 more strictly comparable pairs, 7 of which favored the female procedure (by 0.29 to 6.47 points) and 3 the male procedure (by 1.23 to 2.34). There was also no significant difference in work value per minute.

Two things reconcile it with ours. The first is sample size. With 10 pairs, a test of direction cannot reach significance unless 9 of the 10 fall on one side; their 7 of 10 gives $p = 0.34$, while our 41 of 55 gives $p = 0.0004$. A null result at 10 pairs says what that sample could detect; it does not show that there is no effect.

The second matters more. The two studies ask different questions. Hathaway searched the whole code set for strictly comparable pairs and found only 10. Penn accepted 55 under a looser anatomical match, and our own review flags 15 of those as questionable. Hathaway asks whether strictly comparable procedures are valued differently. Penn compares a broader set of 55 anatomical pairs. Within that set, the average gap widened under every exclusion we tested.

Two public versions of this study give different counts. The journal abstract reports ten directly comparable pairs, seven favoring the female procedure. The authors' public summary in AUA News (July 2024), which includes a code table, reports nine pairs, six favoring the female procedure. We cite the abstract above and note the discrepancy rather than reconcile it; the full article is behind a paywall.

Does the gap survive matching on how demanding the operation is?

The most common objection to a comparison like this is that the two procedures are not equally demanding, so they should not pay the same. Medicare does not measure difficulty directly, but it does classify every procedure code in its fee schedule as major surgery, a minor procedure, or an add-on code, according to how much follow-up care is built into the price: 90 days for major surgery, 10 days or none for a minor procedure. On that classification, 88% of the male-anatomy codes in these pairs are major surgery and 12% minor. Of the female-anatomy codes, 62% are major surgery, 33% minor, and 5% are add-on codes. As a result, 17 of the 55 pairs are classified differently on the two sides: 15 set a major operation against a minor procedure and 2 set a full operation against an add-on code.

17 pairs · classified differently

$260

Average 2025 gap, favoring male anatomy

38 pairs · same classification

−$0.77

Average 2025 gap, slightly favoring female anatomy

Those 17 pairs account for the whole of the dollar difference. Their average gap in 2025 is $260. In the other 38 pairs, where both procedures carry the same classification, the average gap is close to zero and slightly in favor of the female-anatomy procedure (−$0.77), although individual pairs still differ substantially. The same classification does not establish that the two procedures are equally demanding; it only removes the most visible mismatch.

The trend is a separate question, and it holds. In those 38 evenly matched pairs the gap moved $7.47 toward the male-anatomy procedure between 2023 and 2025 ($p = 0.0012$), compared with $4.26 across all 55 ($p = 0.014$). The increase is larger among pairs with matching global periods. The table shows the same pattern under every grouping we tried.

Panel	n	CY2023	CY2024	CY2025	Change	p
All 55 pairs (as published)	55	$75.73	$78.17	$79.98	**+$4.26**	0.014
Mismatched global period	17	$263.42	$264.46	$260.48	**−$2.94**	0.105
Matched global period	38	−$8.24	−$5.17	−$0.77	**+$7.47**	**0.0012**
Both sides 90-day major surgery	32	−$12.04	−$8.56	−$3.48	**+$8.56**	0.0016
Matched and audit-clean	30	−$0.84	$1.26	$5.56	**+$6.40**	0.0004

Negative figures favor the female-anatomy procedure. Classifications are from the 2025 fee schedule (CMS global-period field: 000 endoscopic or minor, 010 minor, 090 major surgery).

Where the dollar gap concentrates: the minutes

That Medicare classes female-anatomy procedures as minor so much more often is not a neutral fact in itself, but it is where the dollar gap concentrates. The work points for a code are set from the operating times that surgeons report about their own procedures to the AMA committee, and two studies have tested those reports against the record. Chan and colleagues (New England Journal of Medicine, 2019) compared the committee's time estimates with benchmark times for 293 procedures; urology was one of two specialties paid more than the benchmark times would support, by about $40 million over 2011 to 2015. Uppal and colleagues (Obstetrics and Gynecology, 2021) compared 901,917 operations in the ACS NSQIP registry with the same survey data and found that urology overstated operating time by a median of 20 minutes, and that the specialties which overstated most earned the most per hour (r = 0.87).

Chan et al. · NEJM 2019

293

procedures benchmarked; urology overpaid ~$40M, 2011–2015

Uppal et al. · Obstet Gynecol 2021

20 min

median urology overstatement across 901,917 operations

RAND for CMS · 2025

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study codes with schedule time significantly above the record

Code-level operating times from the record became available in September 2025, when RAND, in work funded by CMS, compared the fee schedule's times against the NSQIP registry and against anesthesia records for 711 codes. That file covers 25 of the 93 codes here. For 18 of them the fee schedule's time is significantly longer than the recorded time, by up to 137 minutes. Measured in minutes of overstatement against the registry, the male side

runs a median 10 minutes over the record and the female side 6.2, the same direction Uppal found, although with this few codes the difference could be chance (p = 0.41); the comparison against anesthesia records, on fewer codes, points the same way and is also not significant (p = 0.31). These studies raise questions about assigned operating times; they do not establish that the global-period classifications are wrong.

The two kinds of evidence answer different questions. RAND shows that the fee schedule's times are unreliable in general, on both sides of this comparison. Whether that unreliability falls unevenly by sex is not established by this data. Uppal's specialty-level finding and the classification split above suggest it may, but a code-level test on these pairs is underpowered, and sex-specific misvaluation remains unproven.

Published clinical durations point the same way for most of the codes we checked:

Procedure	Published source	Published time	Fee schedule
55250 Vasectomy	Cochrane review, 2 trials (n = 100; 1,429)	20–24 min; most <11	**41 min**
58565 Essure	FDA-mandated follow-up (n = 578)	9 min	**50 min**
58100 Endometrial sampling	Mishra et al., 2025	~3.7 min	**10 min**
58558 Hysteroscopy with biopsy	Two RCTs of diagnostic office hysteroscopy (related evidence)	4–14 min	**30 min**
55700 Prostate biopsy (deleted 2026)	Cao et al., 2026	19.7 min	**15 min**

CPT 58558 includes biopsy or polypectomy, so the hysteroscopy times are related evidence rather than a direct check of its 30 minutes. The pattern is not universal: for prostate biopsy the published average is longer than the schedule's. Sources are listed at the end of this brief.

These comparisons are suggestive rather than decisive. Clinical papers measure different things, from time with the scope in to the whole visit, and none matches the fee schedule's definition of operating time. We include them because they support the registry finding that the schedule's times do not track practice. The registry comparison is the stronger evidence because it measures time the same way throughout, and neither source proves that the error runs in one direction by sex.

How to read the study's "30% higher"

Penn et al.'s "percent difference" divides the gap by the average of the two prices rather than by the female price. That formula reproduces their published percentages on all 55 rows, but it means their headline "30% higher" does not mean male procedures pay 30% more than female ones. Measured the usual way, male price divided by female price, the same data give a 23% median and a 75% average, with the average pulled up by a few extreme pairs. We report the study's version first so the numbers can be compared with theirs, and show the alternatives rather than choosing the most dramatic.

What Medicare pays per minute of operating time

The objection that the male procedure is simply the bigger operation can be examined with the minutes CMS itself assigns. With each fee schedule, CMS publishes the minutes of operating time behind every code's work points. Dividing the facility payment by those minutes gives the rate Medicare pays per assigned minute on each side of every pair. Those minutes are part of the valuation system being examined, not an independent measure of clinical workload, so this is a check on internal consistency rather than on actual work.

Measure	CY2023	CY2025
Dollars per operating minute, male / female	$7.48 / $8.20	**$7.28 / $7.88**
Paired t on that difference	p = 0.067	p = 0.113
Pairs where the male side is paid more per minute	21 of 55	24 of 55
Operating minutes assigned, male / female	106.8 / 84.1	**106.8 / 84.1**
Ratio of assigned minutes	1.270	**1.270**

Figure 1

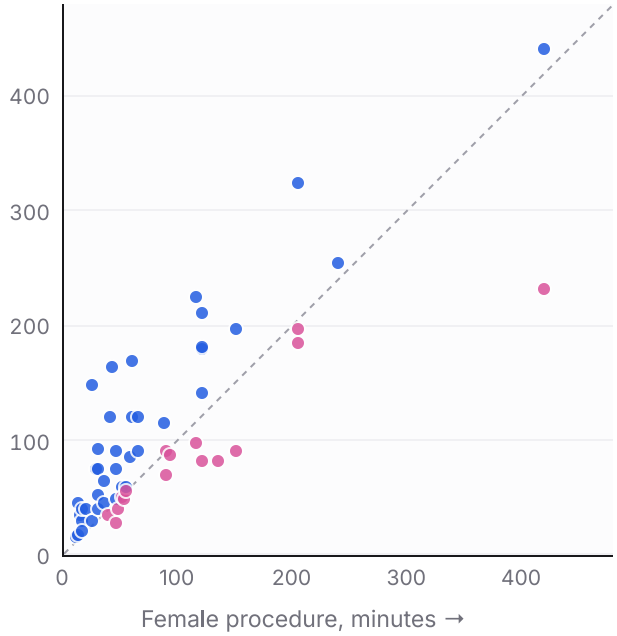
No significant difference per assigned minute. The assigned minutes differ.

Each dot is one pair, female-anatomy procedure on the horizontal axis and male on the vertical. The dashed line is equality: dots above it favor the male side.

Payment per operating minute
Male $7.28 vs female $7.88 · p = 0.11, not significant



Operating minutes Medicare assigns
Male 107 vs female 84 minutes · ratio 1.27×



Male side higher Female side higher

Payment per operating minute and assigned operating minutes, CY2025, all 55 pairs. Left: scatter on both sides of the line, no significant difference (p = 0.11). Right: most dots sit above the line, the male side is credited more minutes. Source: CY2025 facility payment and CMS CY2025 Physician Work Time file.

Per assigned minute the two sides differ by $0.72 in 2023 and $0.60 in 2025, differences that could be chance in both years. The same is true of total time, which adds preparation, recovery and the follow-up visits included in the price ($2.32 against $2.42 per minute, p = 0.28). The difference lies in the assigned minutes. The male-anatomy procedure is credited 106.8 minutes of operating time against 84.1, a ratio of 1.27, and those credits did not change: none of the 93 codes had its operating time revised between 2023 and 2025.

Because the assigned minutes did not change between 2023 and 2025, they cannot explain the increase in the gap over that period; Section 2 traces that increase to practice-cost points. Hathaway and colleagues reached the same conclusion on work points per minute. Two limits apply. The minutes are CMS's own assignments, so a comparison per assigned minute cannot tell us whether the assignments are right; and a difference too small to be distinguished from chance is not proof that the two rates are equal. **What the comparison shows is narrower: divided by CMS-assigned minutes, the payment rates on the two sides are not statistically distinguishable in this sample, while the assigned minutes and the classification differ.** Whether the minute counts reflect the work is the question for the registry studies cited above and for further research.

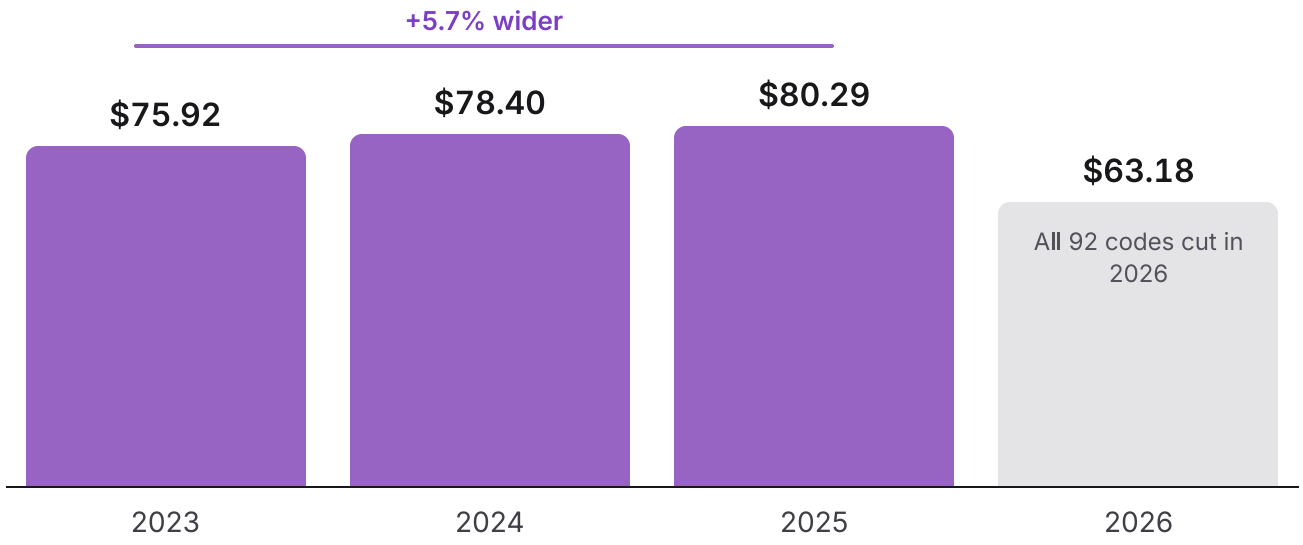
02 The average gap widened from 2023 to 2025.

The four-year table below, Figure 2 and the sensitivity table use the same 54 pairs in every year. CPT 55700 was deleted in 2026, so that pair is left out of every year rather than only the last; otherwise the gap would look smaller simply because a high-gap pair had dropped out. The 2023-to-2025 comparisons elsewhere in this brief (classification, volume weighting, decomposition) use all 55 pairs, because all 55 exist in those years. That is why they show $75.73 to $79.98 (up 5.6%) while the four-year panel shows $75.92 to $80.29 (up 5.7%).

Figure 2

The gap widened through 2025, then shrank in 2026 because CMS cut everything

Mean Medicare facility payment gap between matched male- and female-anatomy procedures, CY2023–CY2026; 54 pairs held constant.



Source: CMS Physician Fee Schedule RVU files CY2023–CY2026, national rates, on the procedure pairs from Penn et al. 2025.

Measure	CY2023	CY2024	CY2025	CY2026
Work RVU gap (mean)	32.0%	32.0%	32.0%	30.1%
Work RVU gap (median)	20.7%	20.7%	20.7%	20.7%
Facility gap (mean)	24.8%	25.3%	25.9%	24.8%
Mean facility dollar gap	$75.92	$78.40	**$80.29**	$63.18
Mean nonfacility dollar gap	$29.97	$34.56	$40.52	$23.00

For 2024 we use the dollar rate of $33.2875 set by the Consolidated Appropriations Act of 2024 from 9 March, which applied for ten of the twelve months, rather than the $32.7442 in the January release. The other years use their January rates, none of which changed mid-year. On a January-only basis the 2024 point would be $77.12 instead of $78.40; the 2023 and 2025 endpoints, and so the trend, are unchanged.

Does the trend survive the source study's weak pairs?

We flag 15 of the 55 pairs as clinically questionable. Two use codes that are different procedures from the ones the study names: the "male sling" code (53448) is removal and replacement of an artificial urinary sphincter, and the "tandem" pair sets a sphincter cuff against a brachytherapy applicator. Five more carry a female-side code whose CMS description does not match the procedure named, two set an add-on code against a full operation, four use codes that are not sex-specific, and two are otherwise not like-for-like. The reason for each is listed in the companion workbook. We re-ran the trend with them removed, step by step:

Specification	Pairs	Gap 2023	Gap 2025	Mean Δ	Median Δ
All 54 panel pairs, as published	54	$75.92	$80.29	**+5.7%**	**+9.6%**
Drop two pairs: codes are different procedures (sling, tandem)	52	$59.15	$64.06	**+8.3%**	**+11.5%**
Drop ten pairs: those two plus the eight flagged on first audit	44	$67.54	$72.13	**+6.8%**	**+3.7%**
Drop 15 pairs: every pair we flag	39	$51.33	$56.26	**+9.6%**	**−1.1%**
Drop 19 pairs: all flagged plus every urethral and penectomy pair	35	$40.76	$46.13	**+13.2%**	**+31.9%**

The panel starts at 54 rather than 55 because CPT 55700 was deleted in 2026, which removes the 55700 / 58100 biopsy pair from every year. Each later row removes the stated number of pairs from that 54. Penn et al. contain two separate prostate-biopsy against endometrial-biopsy pairs with identical names, 55700 / 58100 and 55705 / 58110, which is why pairs are identified here by code rather than by name.

The average gap is larger in 2025 than in 2023 under every version; the median moves less, and is flat once every flagged pair is removed. That is arithmetic on a fixed set of pairs, not a statistical claim. Whether the increase would hold for procedures outside this set is a separate question, and the repeated codes mean the pairs are not independent, so the p-values in this brief should be read as indicative. On the 39-pair panel with every flagged pair removed, the 2023 gap is $51.33 ($p = 0.156$) and the 2025 gap $56.26.

Weighting by how often the procedures are performed

Penn et al. give every pair the same weight, so a procedure performed a handful of times a year counts as much as one performed tens of thousands of times. Weighting by how often Medicare actually pays for each procedure (CMS's 2025 file of 2023 volumes, crosswalked

to 2025 codes) changes the size of the gap considerably but not its direction.

Weighting basis	Mean gap 2023	Mean gap 2025	Change in the gap in points
Unweighted (as published)	$75.73	$79.98	**+10.7%**
Medicare volume, female side	$280.32	$276.38	**+3.3%**
Medicare volume, male side	$224.18	$220.46	**+3.0%**
Medicare volume, lesser side	$371.31	$363.77	**+2.6%**
Medicare volume, both sides	$243.60	**$239.81**	**+3.1%**

This is a sensitivity analysis that answers a different question from the headline: not the average pair, but the average Medicare-paid procedure. Weighted by Medicare volume the 2025 gap is about three times the unweighted figure, $239.81 against $79.98, because the gap is concentrated in high-volume pairs.

The two measures move differently over time. The unweighted dollar gap increased between 2023 and 2025. The volume-weighted dollar gap decreased slightly on every weighting basis, while the volume-weighted gap in points increased; the difference between the two is the dollar rate per point, which fell 4.5% over the period. Both are meaningful. The headline in this brief is the unweighted dollar gap, and its scope is the average pair, not the average procedure performed.

Two codes are effectively dormant. CPT 58565 (Essure) shows a single facility service in the CMS volume file, the device having been withdrawn from the US market in 2018, and CPT 55815 does not appear in the file at all. Both are kept so that the replication matches the published study; the findings hold with or without them.

What moved, and what did not

The gap in work points is identical to the decimal in 2023, 2024 and 2025. That is not rounding: CMS did not revalue the surgeon’s work for a single one of these 93 codes in three years. Since the dollar gap widened anyway, the payment formula can be split into its parts to see which one moved.

Component of the within-pair gap	CY2023	CY2025	Change
Physician work RVUs	+2.4980	+2.4980	+0.0000
Facility practice-expense RVUs	−0.1449	+0.0973	**+0.2422**
Malpractice RVUs	−0.1184	−0.1225	−0.0042
Total RVUs	+2.2347	+2.4727	**+0.2380**
Conversion factor	$33.8872	$32.3465	−4.5%
Resulting dollar gap	$75.73	$79.98	**+5.6%**

Positive figures favor the male-anatomy procedure.

Practice-cost points account for almost all of the movement: in 2023 they ran 0.1449 points in favor of the female-anatomy procedure, and by 2025 0.0973 points in favor of the male-anatomy procedure, a swing of 0.2422 against a total movement of 0.2380. The surgeon's work contributed nothing and malpractice almost nothing.

This rules out two other explanations. Medicare applies one dollar rate to every code, so the two sides cannot be paid differently per point. And that rate fell 4.5% over the period, so the widening cannot be a general increase magnifying two unequal starting values. **The gap in points itself widened 10.7%, moving toward the male-anatomy procedure in 51 of 55 pairs** (in some of them by shrinking a female-side advantage rather than enlarging a male-side one). The dollar figure rose less, by 5.6%, because the falling rate worked against the widening and partly hid it.

03 The 2026 narrowing is a cut, not a correction

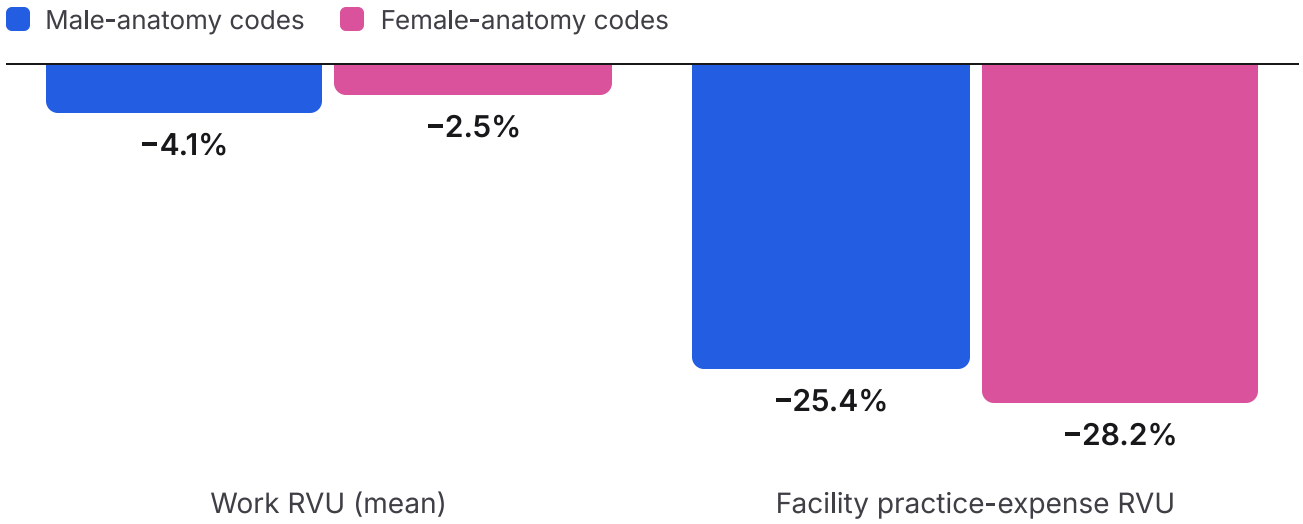
In dollars the gap narrows in 2026, from $80.29 to $63.18. As a share of payment it narrowed only modestly: 25.9% to 24.8% on the average, 14.2% to 14.3% on the median. The reason is that every one of the 92 codes with data was cut in 2026, on both the surgeon's work and practice costs, and not one went up. Women's procedures were not valued more highly. Everything was valued less.

	Mean work RVU change	Median work RVU change	Mean facility PE change
Male-anatomy codes (n = 50)	−4.1%	−2.5%	−25.4%
Female-anatomy codes (n = 42)	−2.5%	−2.5%	−28.2%

Figure 3

Nothing was revalued upward: every code fell on both work and practice costs

CY2025 to CY2026 change in Medicare RVU components, by side of the comparison.



The median work cut was identical on both sides (−2.5%). Source: CMS Physician Fee Schedule CY2025–CY2026.

The median cut to work points was the same 2.5% on both sides, and the median cut to total payment 7.3% pooled across the 92 codes (7.1% on the male side, 8.1% on the female side), so the typical women's procedure saw no relative improvement. Payments are calculated at the January 2026 non-QP conversion factor of $33.4009. Female-anatomy codes were cut harder on practice costs (−28.2% against −25.4%).

The larger average cut on the male side comes from two specific events rather than a broad revaluation: TURP (52601) was revalued down 26%, and prostate biopsy coding was restructured (55700 deleted, 55707–55715 created, 55705 narrowed to non-imaging

approaches). Set aside the three pairs most affected and the remaining 51 still narrow, from $64.17 in 2025 to $55.16 in 2026, a 14% fall against 21% with them in. The two events explain only part of the narrowing.

The gap narrowed because the male side was cut more. The female side was not valued more.

Why 2026 cut everything, and why that narrowed the gap

The dollar rate per point actually rose 3.26% in 2026 ($32.3465 to $33.4009), so fewer points does not automatically mean less money. We checked: 92 of 92 codes pay less in 2026 than in 2025, and none pay more. The average change is −8.0% and the median −7.3%.

Two 2026 fee-schedule policies explain it. Neither has anything to do with the sex of the patient.

2.5% “efficiency adjustment”

Applied to the work points of most services that are not billed by time. CMS based it on the productivity figure in the Medicare Economic Index over five years. Office visits, care management, behavioral health, telehealth and maternity bundles are exempt. This is why the typical code on both sides was cut by 2.5%.

A change to practice-cost points

For procedures performed in a facility, CMS halved the share of indirect practice costs that are tied to work points, compared with the office setting. This is why facility practice-cost points fell 25% to 28%.

These procedures were cut harder than the fee schedule as a whole, but the right comparison matters. Comparing surgical codes with all services flatters the result, because about a fifth of the fee schedule is office visits and imaging, which went up in 2026. Compared with other surgery:

Comparison group	n	Mean change	Median change	Codes that rose
The 92 codes in this study	92	**−7.99%**	**−7.30%**	**0**
All actively priced facility services	7,215	−4.24%	−5.13%	1,493
of which services for which the global surgical concept does not apply (XXX)	1,433	+0.84%	+1.77%	1,003
of which surgical (000/010/090 global)	5,300	−5.45%	−5.63%	415
minor procedures (000/010 global)	1,597	−7.16%	−7.82%	97

Against other surgery, these codes were cut 1.5 times as hard on the average and 1.3 times on the median, about a third to a half harder, and none of them went up.

The narrowing follows from arithmetic. Both policies scale with work points, and the male-anatomy procedures in these pairs carry more work points, so a flat percentage cut takes more dollars off the male side. Average payment across the 92 codes fell 8.0%, but the average dollar gap fell 21.3%, about two and a half times faster. The relative gap barely moved, and the typical pair is no closer to parity than it was.

Policy sources: CMS-1832-F, CY2026 Medicare Physician Fee Schedule final rule (Federal Register, 5 November 2025); CMS CY2026 PFS fact sheet. All payment figures above are our own calculation from the 2025 and 2026 RVU files. The 2026 increase in the dollar rate includes a 2.5% one-year uplift set by statute; the CY2027 proposed rule (July 2026) lowers both rates as it expires, to $33.1693 and $32.8409.

04 How does commercial insurance compare?

Commercial contracts are commonly priced as a percentage of Medicare, on the same points, so a plain male-versus-female comparison in commercial data would be expected to repeat the Medicare gap. The question that adds information is whether insurers apply a lower multiple of Medicare to women's procedures than to men's. We tested this two separate ways.

4a. Published contracted rates, complete coverage of the 93 study codes

All 93 codes, 101 payers, 2.29 billion dollar-denominated rate records from the insurers' published price files as supplied by Payerset (2.34 billion before excluding non-dollar rate types; see Sources).

Figure 4

Commercial contracted rates run about 1.45× Medicare, with a slight tilt toward male-anatomy procedures

Median contracted commercial rate as a multiple of Medicare, by side of the comparison.



Median per-pair ratio 1.045; geometric mean 0.992. Source: Payerset price files, May 2026; CMS Physician Fee Schedule CY2025.

The relative gap is almost the same as Medicare's: 26.4% in commercial contracted rates against 26.7% in the Medicare fee schedule. The dollar gap is about 1.5 times larger: $124 per procedure in contracted rates against $80 under the fee schedule. The same relative disadvantage, applied to a bigger number.

Pair by pair, the median ratio of the male multiple to the female multiple is 1.045, and in 43 of 55 pairs the male side receives the higher multiple. Three standard tests give different verdicts on that, and the disagreement is informative:

Test	What it measures	Result
Sign test	Direction only	p < 0.0001 Significant
Wilcoxon signed-rank	Direction and rank order	p = 0.0034 Significant
Paired t on log ratio	Magnitude	p = 0.853 Not significant

The tilt is consistent in direction and very small in size. The geometric mean of the per-pair ratio is 0.992, effectively neutral, because the minority of pairs that favor the female side do so by larger margins. Reporting only the sign test would overstate it; reporting only the t test would miss a real pattern in direction. We show both.

Does this allow for commercial simply paying more?

Yes. The percentage gap is calculated male against female within each payer type, so the overall level cancels out. A worked example, prostatectomy against hysterectomy:

	Male (CPT 55801)	Female (CPT 58150)	Male / female
Medicare facility payment	$1,061.94	$993.04	**1.069**
Commercial contracted rate	$1,577.18	$1,473.00	**1.071**
Commercial as multiple of Medicare	1.49×	1.48×	—

Commercial marks up both codes by almost the same multiple, so the male-to-female ratio comes through untouched: 1.069 under Medicare, 1.071 under commercial. Across all 55 pairs the median ratio is 1.163 under Medicare and 1.201 under commercial.

Is there a gap within commercial?

Yes, 26.4%

Is it worse than Medicare's in relative terms?

No, vs 26.7%

Is the dollar gap larger under commercial?

Yes, substantially

The dollar comparison is left unadjusted, because the dollars are what a practice experiences.

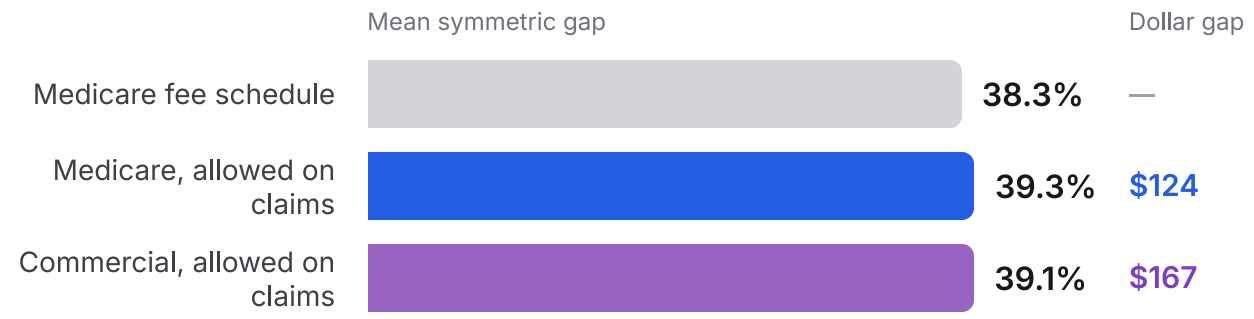
4b. Allowed amounts observed in claims

2025 claims for procedures performed in a facility, 29 matched pairs with enough volume.

Figure 5

Commercial carries the gap over; it does not correct it

Relative gap under the fee schedule and in allowed amounts on Medicare and commercial claims, CY2025.



Source: national all-payer medical claims, CY2025, facility setting; CMS Physician Fee Schedule CY2025.

The median tells the same story: commercial claims paid 26% less for the female-anatomy procedure in the typical one of these 29 pairs.

In claims, commercial pays 1.10 times Medicare for male-anatomy procedures and 1.10 times for female, a ratio of 1.003 that could be chance. Requiring anywhere from 1 to 250 claims per procedure before including it moves that ratio only between 0.970 and 1.003.

Which claims belong in a comparison like this is a matter of judgment, so we defined the population four different ways and re-ran it each time:

Definition of the claim population	Pairs	Medicare gap	Commercial gap	Multiplier ratio
Place of service only	30	42.9%	42.6%	0.994
Revenue code and type-of-bill both absent	29	39.3%	39.1%	1.003
Claim type = professional	29	39.3%	39.1%	1.003
Closed (adjudicated) claims only	28	38.3%	36.6%	0.995

Under every definition the two gaps stay within about two points of each other and the multiplier ratio stays close to 1.

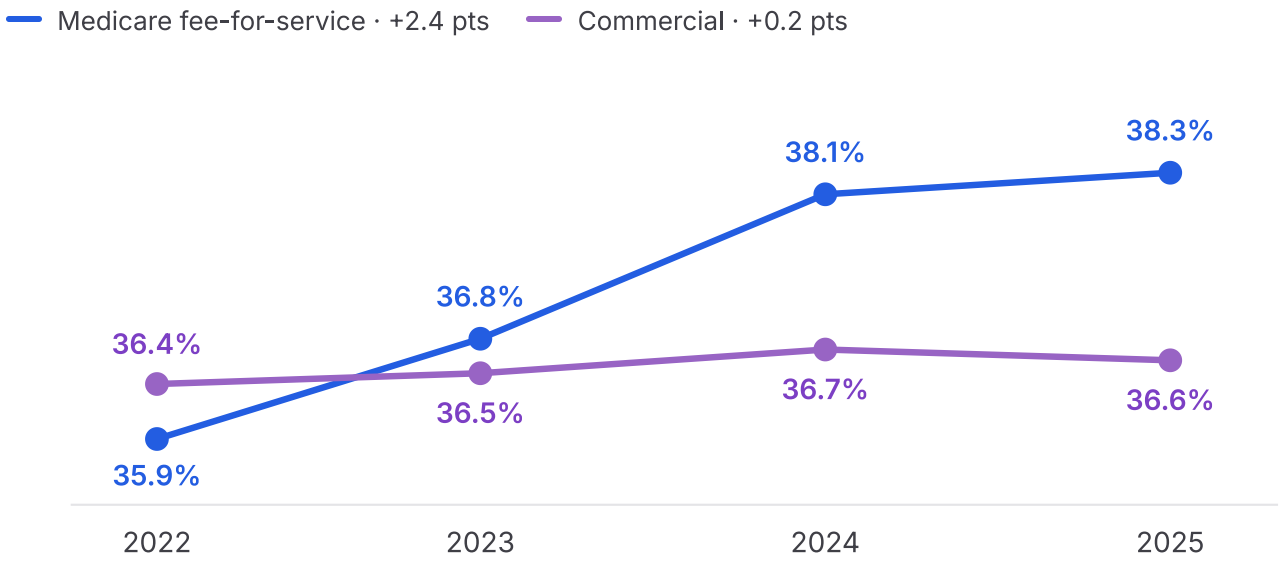
4c. Has the commercial gap widened too? No clear widening detected

The trend in Section 2 is a Medicare finding, because the Medicare fee schedule is published every year and can be compared year to year. Our posted-rate extract covers May 2026 only, so we assess changes over time using claims, and we have four full years of them. On 28 pairs present in all four years (one fewer than in 4b, which is why the 2025 Medicare figure here is 38.3% rather than 39.3%):

Figure 6

Medicare’s gap widened from 2022 to 2025. No clear commercial widening was detected.

Gap in allowed amounts between the male- and female-anatomy procedure in each matched pair, CY2022–CY2025, 28 pairs.



Medicare widened in 20 of 28 pairs (p = 0.007); commercial’s change cannot be distinguished from none (p = 0.35). Source: national all-payer medical claims CY2022–CY2025, physician claims, facility setting.

Medicare’s gap in allowed amounts widened by 2.4 percentage points, in 20 of 28 pairs (p = 0.007). That confirms Section 2 independently, using allowed amounts observed in claims rather than published rates. Commercial moved 0.2 points, which cannot be distinguished from no change (p = 0.35).

In this sample, no clear widening of the commercial gap was detected. In 2022 the two were nearly equal (35.9% against 36.4%); by 2025 Medicare had moved ahead (38.3% against 36.6%). A plausible reason is that many commercial contracts are fixed-dollar fee schedules rather than a percentage of Medicare, so they do not reprice automatically when Medicare’s points move. We can see the pattern but cannot confirm the reason from this data.

The multiplier test holds in every year. The ratio of the male multiple to the female multiple was 1.011 in 2022, 1.014 in 2023, 0.999 in 2024 and 0.993 in 2025, and in no year could it be distinguished from 1. In none of the four years do the claims show a consistent difference in the multiple applied to the two sides.

4D · CONCLUSION

What we conclude, and what we do not claim

The small tilt in posted rates does not appear in allowed amounts on claims, and that is not a contradiction. Posted rates and allowed amounts track each other closely in level (rank correlation +0.90 across 60 codes, shown in Section 5). The posted-rate tests detect a consistent direction but a small size; the claims tests detect neither. Neither source establishes a larger relative gap under commercial insurance. **The defensible statement is narrower: the available claims do not show a consistent additional commercial markup on male-anatomy procedures.** The relative gap in commercial payment is about the same as Medicare's, and because commercial pays more overall, the dollar gap per procedure is larger.

05 Posted rates vary more than eight-fold for the same procedure, and allowed amounts sit near the bottom

We compared the contracted rates insurers published in May 2026 with the median amount allowed on 2025 commercial claims for the same codes, in the facility setting, on lines with no modifier (60 codes). The two sources are not matched contract by contract, and the claims field is an allowed amount, not what a practice collected, so this is a descriptive comparison of two distributions.

+0.90

Rank correlation. A price file reliably tells you which procedures pay more than others.

8.5×

Typical posted range for one procedure, 10th to 90th percentile; 2.3× from the 25th to the 75th.

1.01×

Posted 25th percentile over the allowed amount, on median. The posted median is 1.40×; the 75th percentile 2.29×.

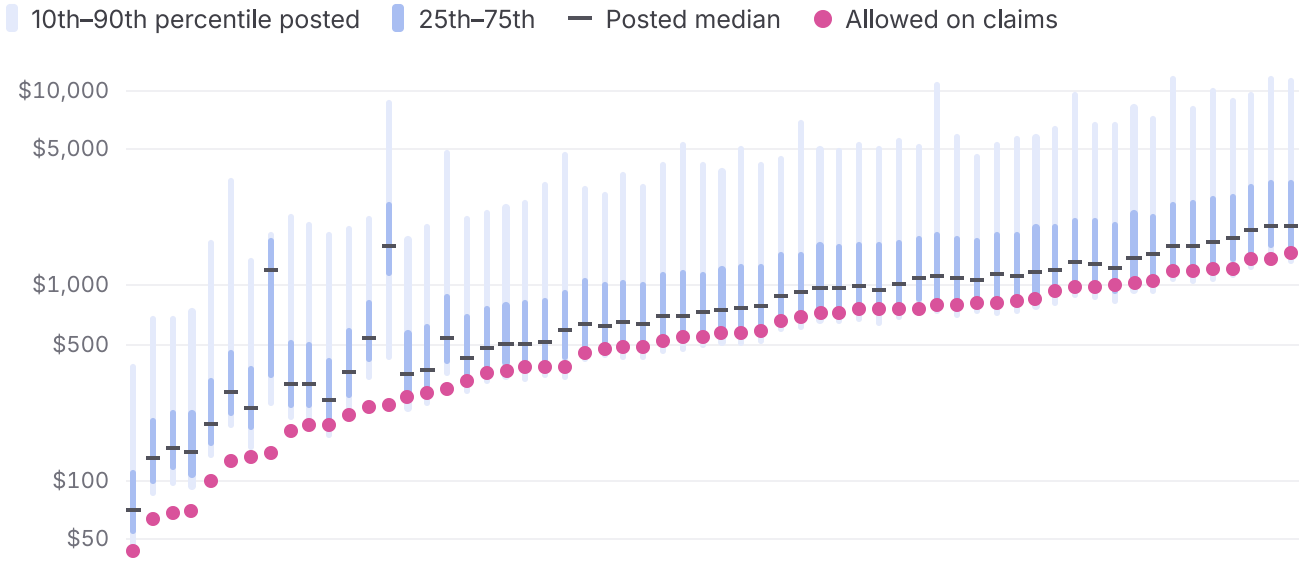
The allowed amount sits near the bottom of that range, and fell below the posted median on 100% of codes. That is a statement about the middle of the distribution, not about individual codes: the posted 25th percentile is within 1% of the allowed amount for only 12 of the 60

codes, and within 10% for 45.

Figure 7

The allowed amount sits below the posted median on every code

Posted rate range (May 2026 price files) against the median amount allowed on CY2025 commercial claims, per procedure code. 60 codes ordered by amount allowed; log scale.



Source: Payerset price files May 2026 against national all-payer medical claims CY2025.

Why posted and allowed differ

Two sensitivity checks narrow the possibilities without settling them. The posted-median-to-allowed ratio is 1.40 on lines with no modifier and similar on assistant-surgeon and multiple-procedure lines, which suggests payment-reducing modifiers are not driving it, although the allowed field may not reflect modifier adjustments. Lines with a zero allowed amount are excluded from both sides, which restricts the sample rather than showing that denials have no influence.

One possible explanation is weighting. A price file lists rate records, each counted once in the percentiles, while allowed amounts are weighted by volume, which tends to concentrate in large, lower-priced contracts. That is a plausible mechanism, and CMS gave similar reasons for adding a utilization file to the price files (see below), but we have not demonstrated it: doing so would require matching claims to contracts, and knowing how many distinct contracts each rate record represents, which this data does not allow.

For practices

A posted median is not an estimate of what a procedure will be allowed, let alone collected. A practice modeling revenue should start from its own claims, by payer and setting, rather than from a price file.

This agrees with the direction of policy. In November 2026 CMS finalized a Transparency in Coverage rule (CMS-9882-F) adding a utilization file and an executive accuracy attestation to the price files, citing the accuracy and usability of what insurers post.

Separately, the curated subset of rates we started with overstated commercial rates by roughly 23% against full coverage (ratio 0.811), similarly on both sides, with little change in the male-to-female ratio.

06 What this looks like procedure by procedure

The figures above are averages across 55 pairs. This is what they look like one operation at a time, with the 15 flagged pairs left out. Among pairs where both procedures are classified as major surgery, the largest gap is subtotal prostatectomy (CPT 55821) against abdominal trachelectomy (CPT 57530): Medicare pays $814 for the former and $366 for the latter. These are matched procedures, not the same operation on different anatomy; only a handful of the 55 pairs are literally the same operation.

Figure 8

Matched operations, priced differently depending on the anatomy

Medicare facility payment for each procedure in a matched pair, CY2025. The eight largest gaps favoring the male-anatomy procedure and the four largest favoring the female.



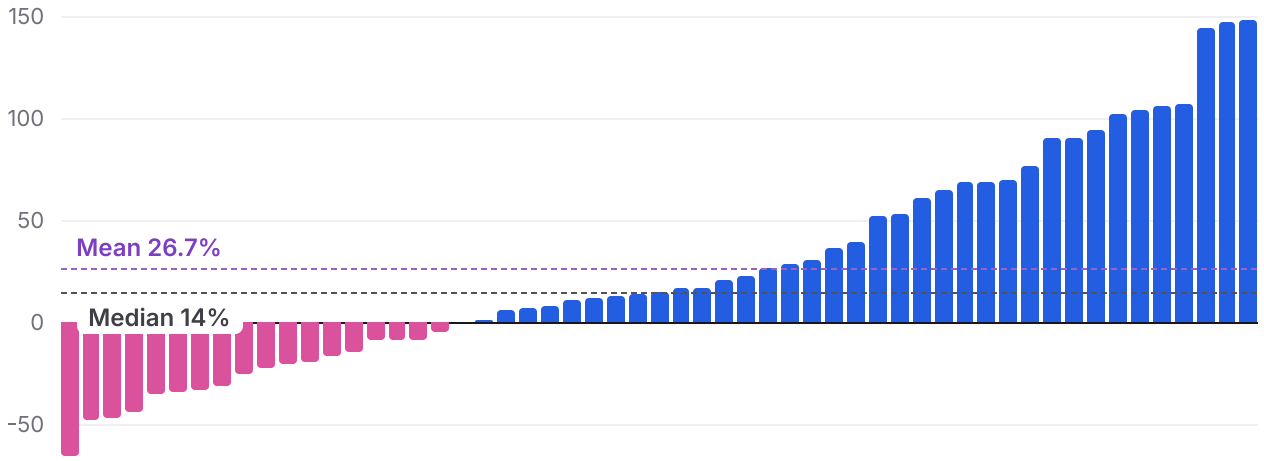
Each row is one matched pair: the upper label is the male-anatomy procedure, the lower the female. Excludes the 15 pairs judged clinically questionable, including seven whose codes are not the procedures the study names. Source: CMS Physician Fee Schedule CY2025, national rates.

The comparison is not one-sided. Four of the twelve pairs shown pay more for the female-anatomy procedure, and across all 55 pairs in 2025, 19 do. The finding is a consistent tilt rather than a uniform rule, which is why the spread below matters as much as the average.

Figure 9

A consistent tilt, not a uniform rule

Symmetric percent difference for each of the 55 matched pairs, CY2025 Medicare facility payment. Bars above zero favor the male-anatomy procedure.



The mean sits above the median because a small number of pairs are extremely skewed. Source: CMS Physician Fee Schedule CY2025, all 55 matched pairs.

07 Method, checks and limitations

SOURCES

CMS fee schedule

Physician Fee Schedule relative-value files, 2023 to 2026. National rates, with no geographic adjustment. Checked line by line against the official CMS release for 2026: no mismatches across the 92 codes in the study.

Insurer price files

Insurers' published price files as supplied by Payerset (May 2026 rollup): 2.34 billion source rate records for the 93 study codes across 101 payers, of which 2.29 billion are retained after keeping dollar-denominated rate types (negotiated and fee-schedule rates; derived, percentage and per-diem records excluded). Every retained record is a professional-service rate in an inpatient, outpatient or combined facility setting; there are no office-setting rates in the source. Per-code percentiles are computed directly over the retained records with BigQuery's approximate quantile function (1,000 intervals). We have not verified that each record is one distinct contract or that coverage of contracted prices is nationally complete.

All-payer claims	A national all-payer medical claims database, 2022 to 2025. Payers are identified by type and subtype rather than by name, which is unreliable on closed claims. Physician claims only; hospital bills are excluded. 2025 is used for the single-year comparisons and all four years for the trend in Section 4c. Extracted November 2026.
Procedure pairs	As specified in Penn et al. (2025), Table 1.

CHECKS PERFORMED

- ✓ The source study's five headline figures reproduced to the cent; its "30% higher" headline comes out at 32.7% on the same formula.
- ✓ The 2026 fee-schedule values checked line by line against the official CMS release; 2023 to 2025 payments recomputed from the CMS RVU files.
- ✓ Median Medicare allowed amounts in the claims extract checked against the fee schedule: 58558 facility $224.33 against $224.48; 58558 office $1,217.33 against $1,207.17; 52601 facility $705.96 against $707.09.
- ✓ Every year-to-year statement uses the same fixed set of procedure pairs. If a pair drops out in one year it is removed from all years, so the trend cannot be an artifact of the sample changing underneath it.
- ✓ The Medicare figures (replication, trend, decomposition, classification, per-minute, volume weighting, 2026 cut) and the claims and posted-rate aggregates were recomputed from the raw files with separate code and matched.
- ✓ Commercial findings re-run requiring anywhere from 1 to 250 claims per procedure before including it, and checked against two separate data sources, published price files and claims.

LIMITATIONS

Pairing. The pairs are the source study's, and reproducing its numbers does not validate its pairing. Checking every code against CMS's descriptions, we flag 15 of the 55 pairs as questionable, and any single pair should be read with that in mind. The headline trend holds with all of them removed (Section 2).

Setting. The same procedure pays very differently depending on where it is performed, and the two cannot be averaged together. CPT 58558, hysteroscopy with biopsy, pays $224 in a hospital and $1,207 in a physician's office on the 2025 fee schedule. That is not a pricing error: in an office the practice buys the scope, the supplies and the staff time, whereas in a hospital those costs are billed separately by the hospital. We therefore only compare procedures with others performed in the same setting. The cost is a smaller sample, because a pair only counts if both procedures have enough volume in that one setting.

Commercial payment coverage. Only about 33% of commercial facility claim lines for these codes carry a positive allowed amount, against about 85% of Medicare lines, and the commercial share differs by side (26.2% on the male side, 36.1% on the female). The commercial claims results therefore rest on a partial and uneven sample. We rely on the Medicare claims, which carry a positive allowed amount on about 85% of lines, for the real-world check above.

Volume thresholds. The size of the gap measured from claims depends on how much volume we require a procedure to have before including it, and moving that threshold moves the figure considerably. The size of the gap measured from the fee schedule does not, because the fee schedule covers every code with no sampling. Every Medicare headline number in this brief is therefore taken from the fee schedule, and the claims are used to confirm direction.

Posted against allowed. The posted-rate comparison in Section 5 sets May 2026 price files against 2025 claims, uses allowed amounts rather than collections, and is not matched contract by contract. It describes two distributions; it does not establish why they differ.

National figures. All payment figures are national. Medicare adjusts by locality, so local amounts differ.

Physician payment only. A surgical procedure also generates a hospital bill, priced by separate systems that are not built on points, which is why the source study and this analysis both stop at the physician side. We did look: on Medicare the hospital bills point the same way and are larger in dollars ($391 per procedure across 16 pairs), and on commercial they lean the same way but could be chance (18 of 28 pairs, p = 0.18). We do not fold these into the headline, and they are measured on different subsets, so they do not establish a combined payment difference per episode.

Scope. The comparison is between male and female anatomy as the source study defined it. It does not address care for transgender patients, and nothing here should be read as doing so.

Earlier commercial specification. An earlier specification of the commercial analysis, using the curated subset of posted rates we started with, 33 pairs and the office-rate benchmark, showed an amplification effect of 6.3% (p = 0.005). It did not survive a like-for-like comparison with allowed amounts on claims and was not retained. We record it here as part of the audit history.

Claims lag. 2026 claims cannot be used for payment analysis yet. Claims take months to finalize, so recent periods look artificially thin. 2025 is the most recent complete year.

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