MAKE AMERICA HEALTHY AGAIN

2026

EXECUTIVE SUMMARY

WOLVES IN WHITE COATS:

How Doctors and Hospitals Pushed and Profited from the Fraud of "Gender Medicine"

In the 2010s, financial incentives contributed to the rapid expansion of pediatric gender clinics and programs by creating long-term revenue opportunities for these medical establishments. Unlike most traditional pediatric services, which involve episodic or short-term care, children receiving puberty blockers, cross-sex hormones, surgeries, and related services may require recurring endocrinology visits, laboratory monitoring, prescriptions, mental-health services, surgical procedures, and follow-up care extending into adulthood. This pediatric medical field effectively creates “captive patients.”

All-payer claims and cost data indicate nearly $120 million in billed charges for sex-rejecting procedures involving minors since 2019. These charges include more than 5,500 surgical procedures and 8,500 courses of hormones or puberty blockers. The analysis concludes that these continuing interventions have created financially valuable patient populations for hospitals and associated specialties.

- Cross-sex hormone therapy entails average yearly payer costs per patient ranging between $545 (androgens), $735 (estrogens), and $16,385 (for the more costly puberty-blocker GnRH). Surgical interventions, such as mastectomies, mammoplasties, and phalloplasties, can range from $12,000 to over $130,000.

Potentially Fraudulent Medical Coding

An analysis of the data suggests that some providers may have used diagnosis codes that did not accurately reflect patients' underlying conditions in order to obtain insurance coverage for sex-rejecting procedures, particularly with ICD-10 code E34.9 (“endocrine disorder, unspecified”) and the ICD-10 codes for central “precocious puberty.”

- Between 2015 – 2025, public and private insurance was billed nearly $50 million for puberty blocking drugs in patients aged 9-17 with Endocrine Disorder diagnoses (excluding precocious puberty, the typical indication for puberty blockers).
- During this same timeframe, nearly $11 million was billed for puberty blockers, including to Medicaid and Medicare, for hundreds of patients between the age of 13 and 17 with a diagnostic code for precious puberty. By definition, anyone 13 or older cannot have a diagnosis of precocious puberty and should not be given puberty blockers at that age for this indication

Federal Policy and Institutional Pressure

The Biden Administration, particularly HHS, under the leadership of Secretary Becerra and Admiral Levine, contributed to the expansion and normalization of sex-rejecting interventions through nondiscrimination policies, insurance requirements, agency guidance, litigation positions, federal employee benefits, and other federal programs.

Influence of Professional Medical Organizations

Organizations like World Professional Association for Transgender Health, the Endocrine Society, the American Psychological Association, and the American Academy of Pediatrics contributed to the promotion of pediatric sex-rejecting interventions, even while undercutting their own evidence base. This professional network created an institutional environment in which sex-rejecting medical interventions became increasingly accepted, while opposing clinical perspectives, uncertainties, and potential risks that caused irreversible damage received insufficient consideration.

Patient and Parent Experiences

Eight first-hand testimonies from patients and parents illustrate weakness in clinical safeguards and informed-consent processes. Common themes include distress related to a child's sex and rapid medical interventions, insufficient examination of underlying psychological, developmental, social, or trauma-related factors, limited discussion of irreversible damage, pressure placed on parents to approve "treatment," adverse physical and psychological outcomes, and difficulty obtaining appropriate medical care after stopping treatment or detransitioning. These testimonies underscore the imbalance between the structured healthcare pathways available for initiating medical transition and the comparatively limited clinical infrastructure available to patients seeking to discontinue treatment, address complications, or detransition.

Conclusion

The expansion of pediatric sex-rejecting procedures resulted from an interaction among financial incentives, potentially illegal billing practices, ideological and professional influences, federal policy, and inadequate oversight. The medical establishment and the government failed innocent children. This report exposes how these calculated financial and political efforts left children irreversibly harmed and abandoned at the very moments when they needed real support.