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The coming NIH cuts

A recently announced policy change about National Institutes of Health (NIH) funding has shone an unflattering light on the federal medical research enterprise. This policy change (which remains on hold, pending appeal) would limit the amount of money research institutions can receive for indirect costs to 15% of a grant.

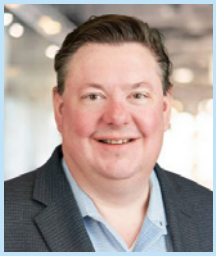
This would restrict how much of a grant's budget can be used for overhead. NIH grants mainly fund direct costs like salaries and supplies, so institutions use indirect funds to maintain a well-equipped research environment (to cover expenses such as building and lab space, utilities, equipment, technology and administrative support). Before the 15% cap, universities, academic medical centers (AMCs) and other research institutions would commonly supplement their grants using a negotiated indirect cost rate—which averages approximately 28% and in some instances climbs higher than 60%, according to NIH.

NIH says it's trying to bring its indirect cost rates in line with those allowed by private funders such as the Bill and Melinda Gates Foundation and the Robert Wood Johnson Foundation. But the policy change would compound an existing problem for research institutions: the NIH's salary cap, which limits the maximum annual salary that can be charged for NIH grants and contracts. Private funders, of course, are not bound by this cap. NIH's salary cap, the practice of which predates the Trump administration, was recently raised to $225,700 for 2025.

This figure is artificially low, as we'll see in a moment. The combination of NIH's indirect cost rate cap and its salary cap produce difficulty for research institutions. It boils down to this: NIH funds a great deal of medical research (about 20% of total U.S. medical research, according to one estimate), but direct research costs more than NIH is officially willing to pay. Institutions must find dollars however they can. Privately funded research can limit its indirect cost rate to 15% because it pays "full freight" on actual researcher salaries.

The 'fuzzy math' of research funding

Calling attention to how institutions move dollars around to support their research misses the point. We should not blame institutions or individual researchers for playing by the rules that they did not create.



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Let's use cancer as an example. Working oncologists who can conduct research have, in rough terms, three options: 1) conduct NIH-funded research; 2) conduct privately funded research; or 3) treat patients exclusively.

Oncologists don't work for free. In 2024, the median total compensation for oncologists was $544,722, according to data from the Medical Group Management Association. That amount may strike some Americans as high; but it's what the market requires. Remember that the NIH caps the researcher's salary at $225,700. An AMC that wants an oncologist researcher to work on an NIH-funded grant must find a way to cover the cost of that researcher.

Consider the following example (Figure 1): it assumes an oncologist who spends 50% of their working time doing research. (In this example, as often happens, a researcher budgets part of their time on research and the remainder treating patients.) Half of the oncologist's $544,722 must be paid for somehow. Because privately funded research often fully compensates the researcher's actual salary, it can easily cap the indirect costs. But NIH can't do that because of the salary cap, so the institution needs to find $132,655 to make the researcher whole.

Figure 1: *Theoretical comparison of an oncologist conducting research at 50% time, privately funded vs. NIH-funded research**

	Private	NIH
Costs		
Direct (Salary)	$ 272,361	$ 272,361
Indirect @ 15%	$ 40,854	$ 40,854
Total Cost	**$ 313,215**	**$ 313,215**
Funding		
Direct	$ 272,361	$ 112,850
Indirect @ 15%	$ 40,854	$ 16,927
Total Funding	**$ 313,215**	**$ 129,777**
Costs vs Funding	$ –	$ (183,438)

** Assumes an annual total compensation (salary, benefits and bonus) of $544,722: the 2024 median for oncologists*

Do we get our money's worth from NIH?

The indirect cost rate question feeds into a broader issue of whether NIH wastes money. Some policymakers believe that research institutions are inflating indirect costs; they see the new cap as a way to cut what they consider wasteful spending. But that also misses the point. NIH makes funding decisions without regard to whether the end product is financially viable. If Americans can lead healthier lives as a result of the findings, it's considered good research.

It's worth asking whether the American public benefits from NIH-funded research. The answer is undeniably yes. Scientists employed or supported by NIH have won the highest awards possible, including Nobel Prizes; but more important than the honors are the measurable benefits for patients. These include:

- **Targeted cancer therapies:** NIH-supported studies have been instrumental in developing treatments that precisely target cancer cells, minimizing harm to healthy tissues. These advancements have contributed to a 33% decline in cancer mortality over the past 3 decades, resulting in approximately 4.1 million lives saved between 1991 and 2021.
- **Cardiovascular care:** Initiated in 1948 with NIH funding, the Framingham Heart Study identified key risk factors for cardiovascular diseases, such as high blood pressure and cholesterol. The insights gained have led to preventive measures and treatments that have significantly reduced heart disease-related deaths.
- **HIV/AIDS research:** NIH research has been pivotal in developing antiretroviral therapies and preventive strategies, leading to a more than 90% decrease in the number of U.S. children infected with HIV at birth.
- **The Human Genome Project:** This massive project, completed in 2003 with significant funding and leadership from the NIH, was a landmark international effort to map all 3 billion base pairs of human DNA. This foundational achievement has transformed biomedical research, enabling breakthroughs in disease gene identification, precision medicine and targeted therapies. It has paved the way for earlier diagnoses, more personalized treatments and a deeper understanding of the genetic basis of disease.

This is medical research in action: scientific inquiry that leads to direct benefit for patients. But that costs money.

For AMCs, this is brass-tacks time. AMCs have for decades both supported and benefitted from the vast U.S. medical research enterprise. If indeed the NIH funding stream is threatened long-term, AMCs should assess the potential impact and explore alternative funding sources, such as new partners and philanthropic support. Strengthening internal alignment around research priorities can help maximize limited resources. Preparing now ensures continued innovation and impact, even in a leaner funding environment.

Beyond that, we collectively have to face an uncomfortable set of questions. Do we, as a nation, really want to cure disease? If so, what are we willing to pay for it? And if not, are we prepared to face the consequences of that? Let's confront these directly rather than singling out researchers or research institutions for playing by a set of rules that may seem arcane.

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