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Trump Cuts to Scientific Research Funds Jeopardize Public Health

By Mehrin Masud-Elias2025-03-25T04:30:04000-04:00

The National Institutes of Health dealt a stunning blow to the US scientific and medical research communities in February by trying to impose a 15% cap on grant recipients' indirect costs. This includes reimbursements for "go forward expenses" on existing awards to institutions of higher education.

The cap could reduce indirect funding payments distributed to 149 US medical schools by as much as $3.3 billion, and the NIH itself estimates this move would shave $4 billion a year from payments for medical research by the agency.

A federal court in Massachusetts placed the cap under a temporary restraining order in March. The presiding judge provided a painstaking analysis in support of her decision and stated that the NIH's action was "arbitrary and capricious," "impermissibly retroactive" and contravenes Congress' prior appropriations provisions on this very topic.

If allowed to move forward, the cap has the potential to threaten public safety and stunt economic development in profound ways.

Such a seismic shift in NIH policy would affect all US researchers, including physicians studying cancer, rare diseases, infectious diseases and other critical public health issues. It will hit especially hard those who are just entering the profession, such as junior doctors and researchers, graduate students, and post-docs.

The fate of all ongoing federally funded, critical research, including maternity care and opioid addiction, is potentially jeopardized. Patients who rely on clinical trials as a last resort to extend their life, improve their quality of life, or be cured may be left with no viable alternatives.

The potentially adverse effects of a weakened research infrastructure in the US—including on clinical trials testing innovative therapies for complex diseases—would affect everyone who has the potential

to benefit from such research.

The American Association of Medical Colleges say the rate cap is substantively and procedurally faulty. Rate changes, especially those enacted midstream, need advance notice. They should be evidence-based and give the awardee a chance to negotiate the rate based on their individual circumstances.

None of that was done here. Instead, NIH provided the following justifications for the 15% rate cap:

- To bring it in line with what philanthropic foundation research funders allow
- To make more funds available for the direct costs of research
- Because NIH is statutorily authorized to change such rates

As noted in the judge's decision granting the temporary restraining order, NIH's justifications are based on faulty premises. Foundations have different goals than the federal government. Research is highly dependent on indirect costs. And existing regulations limit when and how an awarding agency can deviate from the negotiated rate and require the agency to document and justify any deviation.

Indirect facilities-and-administration costs—the lifeblood of institutions of higher education and teaching hospitals—are those incurred for general operational, administrative, and other overhead expenditures. These costs can't easily be assigned to a specific research project or clinical trial. They pay for researchers and their staff as well as janitorial workers and other employees who help support the research enterprise.

Examples of such costs, as cited by AAMC in its complaint for injunctive relief, include maintaining research laboratories; data processing, security, and storage; laboratory equipment; radiation safety and hazardous waste disposal; and support personnel.

Because these costs bolster the entire research enterprise of federal grant awardees and differ from institution to institution based on their size, geographic location, and other factors, each awardee has negotiated indirect cost rates (ranging from 30% to 60% with an average rate of 28%) individually with NIH based on audited financial statements.

A blanket, one-size-fits-all approach of 15% is unprecedented. The shortfall would be exacerbated because the 15% cap would apply to existing grants for expenses going forward at higher education

institutions. This would throw long-term planning, budgeting, and personnel expenses for a university's research administration function into disarray, even if the overall grant amount or direct cost stayed the same.

Higher education institutions with large endowments couldn't necessarily use them to cover such a shortfall, because they're usually restricted for donor-designated purposes, which may not cover research.

NIH's rate cap—coupled with across-the-board federal funding freezes and staff and budget reductions at federal science agencies—likely will hurt state economies, especially in places with large universities and affiliated teaching hospitals, due to worker layoffs.

Many technologies developed at higher education institutions and their teaching hospitals are licensed to US industry, such as biotech and pharmaceutical companies, which in turn drives US economic growth. The unparalleled reputation of the US as a world leader in scientific and medical research would take a hit if the pipeline for the next generation of researchers, and the innovations they foster, is blocked.

Cutting-edge research, as well as critical public health research, keep the US public safe. It helps federal and state governments prepare for emerging threats and emergencies from climate change, agriculture, infectious diseases, and more. The NIH's rate cap threatens this research and public safety, and it must be reconsidered.

The case is Commonwealth of Massachusetts v. NIH , D. Mass., No. 1:25-cv-10338, 3/5/25 .

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