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INSIGHT

NIH Indirect Costs Policy for Research Grants: Recent Developments

Updated April 17, 2026

On February 7, 2025, the National Institutes of Health (NIH), an agency of the Department of Health and Human Services (HHS), published supplemental policy guidance that instituted a 15% indirect cost rate for NIH grants. This policy would have applied to any new grant awards and to all existing grants to institutions of higher education (IHEs) for the reimbursement of expenses incurred from February 10, 2025 onward. Indirect costs represent expenses that are not specific to a research project and that maintain the infrastructure and administrative support for federally funded research.

On April 4, 2025, the U.S. District Court in Massachusetts permanently enjoined (i.e., prohibited) HHS from implementing this policy, which was upheld on appeal by the First Circuit Court of Appeals on January 5, 2026. Congress has legislative power to determine indirect costs policy at NIH and could consider whether and how to respond to NIH's indirect cost initiatives through oversight or legislation.

NIH is the leading federal agency for biomedical and health research. Nearly 83% of NIH's budget (total enacted appropriations is roughly $47.5 billion in FY2026) supports extramural research and training programs performed by nonfederal research institutions such as universities and medical centers, mostly through grants. NIH budget data show that out of $34 billion awarded in FY2025, 28%, or $9.5 billion, went toward indirect costs. According to a 2025 economics study, fixing the indirect cost rate at 15% while holding total direct costs constant would reduce total NIH funding for many grantees, with most universities seeing a reduction of 15%-20% of their annual NIH funding, and with resulting savings potentially available for reallocation to other NIH research.

Understanding Indirect Costs for Research Grants

Indirect costs, also called facilities and administrative costs (F&A), represent costs that cannot be easily attributed to an individual research project (e.g., operation and maintenance of research facilities, library expenses) and administrative services (e.g., accounting, payroll, and purchasing). In contrast, direct costs consist of researcher salaries, equipment, supplies, and other expenses that directly support or benefit an individual research project. Because indirect costs cannot be easily attributed to a specific research grant, they are charged using an indirect cost rate applied to a certain portion of the direct costs for each research grant awarded. Each federal research award comprises funding for both direct and indirect costs.

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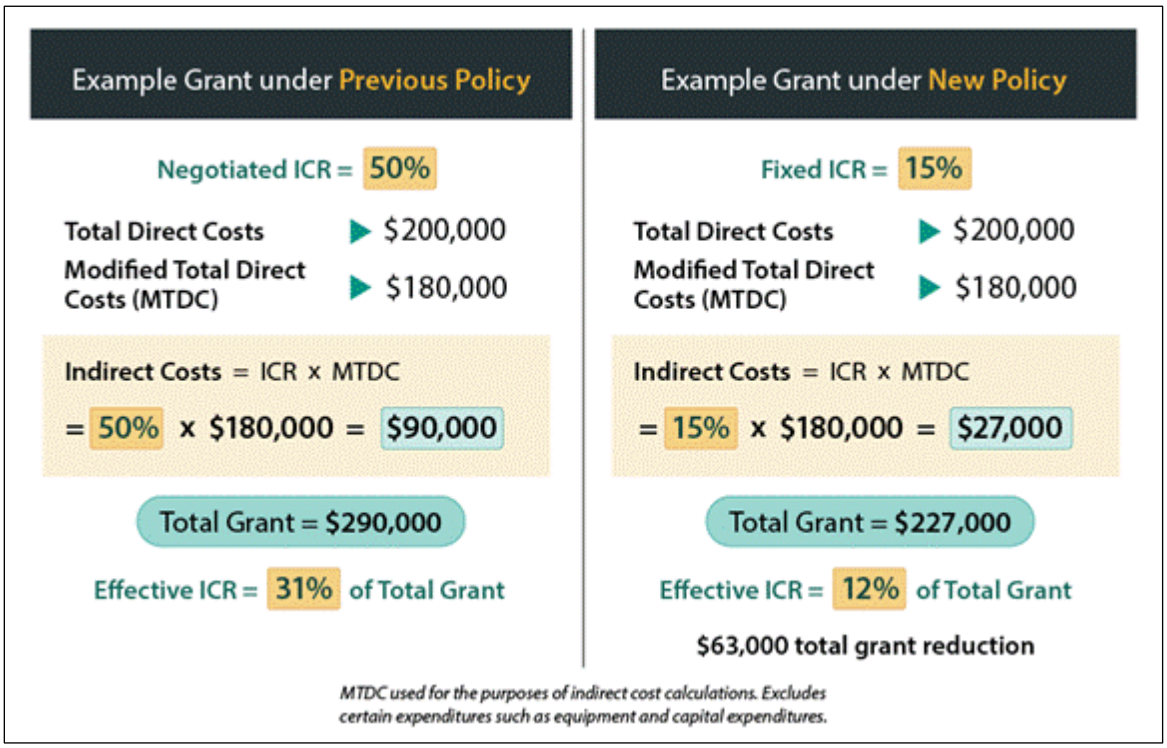
IN12516

Each funded research institution negotiates an indirect cost rate with the federal agency that provides the majority of its federal research funding through a process that focuses on identifying the specific facilities and administrative costs that support research. Most IHEs negotiate their indirect cost rate with HHS's Program Support Center, Cost Allocation Services (not NIH). Generally, the rate stays in effect for two to four years before it is renegotiated. Once an indirect cost rate has been established, federal agencies generally apply that rate to all grants issued to the research institution. Some federal agencies have statutory caps on indirect costs rates. For example, the U.S. Department of Agriculture has a statutory indirect cost cap of 30% for its research and education programs.

According to a 2025 economics study based on data from 354 NIH-funded institutions, most institutions' negotiated rates were between 50% and 70%, averaging 58%. However, *effective* indirect costs rates, meaning the amount of a grant that has effectively covered indirect costs, ranged between 25% and 45% and averaged 42%. The 2025 study also found that effective indirect cost rates have remained relatively constant over recent decades. **Figure 1** shows how indirect costs for a research grant are calculated and how a change in the indirect cost rate would affect the total size of a grant award and the resulting effective indirect costs rate, or portion of the award used to cover indirect costs.

Figure 1. Comparison of Indirect Cost Rate (ICR) Policies: Negotiated ICR Versus Fixed ICR and Resulting Effective ICRs



Source: CRS, based on analysis of regulations and policy.

Notes: Example holds total direct costs constant. Negotiated ICRs vary by institution. Modified total direct costs (MTDC) are typically used by federal grantees and agencies when calculating the indirect costs for an award. Per 2 C.F.R. §200.1, MTDC excludes equipment, capital expenditures, charges for patient care, rental costs, tuition remission, scholarships and fellowships, participant support costs, and the portion of each subaward in excess of $50,000. Total grant reduction reflects savings potentially available for reallocation to other NIH research.

Changing Indirect Cost Rates at NIH: Prior Efforts

As detailed in a separate CRS report (R48540), the federal government has debated and implemented different indirect costs policies since the 1940s. In its FY2018 budget request for NIH, the Trump Administration proposed capping indirect costs for NIH grants at 10% of the total grant cost. In FY2018, the House and Senate Appropriations Committees did not adopt this proposal. To illustrate, the report accompanying the Senate bill (S.Rept. 115-150) stated,

> The methodology for negotiating indirect costs has been in place since 1965, and rates have remained largely stable across NIH grantees for decades. The Administration's proposal would radically change the nature of the Federal Government's relationship with the research community, abandoning the Government's long-established responsibility for underwriting much of the Nation's research infrastructure, and jeopardizing biomedical research nationwide. The Committee has not seen any details of the proposal that might explain how it could be accomplished without throwing research programs across the country into disarray.

The FY2018 appropriations law included a new provision that continued policies related to indirect cost rates that were in effect as of the third quarter of FY2017 and prohibited HHS from developing or implementing a modified approach to determining indirect cost rates (P.L. 115-141; Division H, Section 226). This limitation has been included in annual appropriations acts, including continuing appropriations acts, enacted since then.

Policy Discussion

The February 2025 NIH policy cited that, compared with the federal government, many private foundations provide substantially lower indirect cost rates in their grants to universities (15% or less). According to the Association of American Universities and the Association of American Medical Colleges, private foundation rates are somewhat inapt as a comparison to federal indirect cost rates because foundations and federal agencies categorize direct and indirect costs differently. Also, according to National Science Foundation data, funding from nonprofit organizations, which includes private foundations, constitutes a smaller proportion of total basic research funding (8.4% in 2022) compared with federal funding (39.6% in 2022).

Some have concerns that the current process to negotiate indirect cost rates lacks transparency and may make universities less sensitive to cost-reduction considerations. In response to some of these concerns, a nonfederal Joint Associations Group on Indirect Costs has proposed the Financial Accountability in Research (FAIR) model for calculating indirect costs for research grants, which would shift to indirect costs for each research grant being determined on an actual per award expense basis.

The Consolidated Appropriations Act, 2026 (P.L. 119-75), continued the provision that limits HHS from developing or implementing a modified approach to determining indirect cost rates (§224 of Division B). The explanatory statement accompanying FY2026 appropriations directed HHS and other departments to engage in discussions with Congress on how to improve indirect costs rate policy. In its FY2027 budget for NIH, the Trump Administration again proposed a 15% cap on indirect costs and to eliminate the recurring appropriations prohibition. Congress could decide whether to adopt the FAIR model (or a different alternative process) or NIH's proposed 15% cap, or to maintain the status quo.

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