THE ALLIANCE FOR
LONGEVITY INITIATIVES

A Call for a New National Institute for Healthy Longevity and Aging Research (NIHLAR)

BLUF: In line with the plan to increase efficiency and innovation at NIH, Congress should establish the National Institute for Healthy Longevity and Aging Research (NIHLAR), which will shift our system from "sickcare" to preventive "healthcare" by targeting the root cause of chronic disease–aging–thereby extending the healthy longevity of hundreds of millions of Americans.

Executive Summary

By 2050, Americans aged 65 and older will comprise 23% of the population, fueling a surge in age-related illnesses like cardiovascular disease, dementia, and cancer. Today's healthcare model siloes these conditions, treating each only after it emerges, rather than addressing aging itself. Consequently, many individuals spend nearly a quarter of their life in poor health, with devastating effects on families, the workforce, and the economy.

In response to recent proposals by Congress and the White House's on restructuring and consolidation NIH, the Alliance for Longevity Initiatives (A4LI) is advocating for the creation of the National Institute for Healthy Longevity and Aging Research (NIHLAR) to be housed under the proposed Administration for a Healthy America (AHA) agency. NIHLAR would accelerate breakthrough interventions targeting multiple chronic age-related diseases, complementing the National Institute on Aging's (NIA) current focus on Alzheimer's and related dementias. Aligned with the Make America Healthy Aging (MAHA) initiative, NIHLAR will also promote innovation, foster inter-institute collaboration, and enhance accountability to meet America's growing healthcare needs.

NIHLAR's key strategic objectives include:

1. Focus on Aging Biology: Accelerate interventions—pharmaceutical or lifestyle—that target pathways of aging biology to reduce multiple chronic diseases as we age.
2. Emphasis on Translation: Create specialized divisions dedicated to translating research into applications for clinical practice and public health initiatives.
3. Encourage Innovation: Implement reforms that promote high-risk, high-reward research and bold initiatives that increase human healthspan.
4. Increased Accountability: Define clear, public objectives to ensure accountability and reallocate resources from underperforming programs to more promising projects.
5. Collaboration with Related Agencies: Coordinate closely with the FDA and other NIH institutes to streamline the development and approval of both lifestyle and therapeutic interventions.

The NIHLAR proposal offers a blueprint for modernizing aging-focused research within NIH. If Congress approves the NIH consolidation plan, NIHLAR would become the first institute explicitly dedicated to developing preventative medicine and addressing the multi-morbidity affecting older Americans.

Consequences of an Aging Demography

Since 1950, there has been a dramatic increase in the percentage of Americans aged 65 years and older. Older Americans made up 8% of the population in 1950, 18% in 2024, and will make up 23% of the population by 2050. Because more Americans have made it to older age, our medical system is treating an ever-increasing number of age-related diseases and conditions, placing immense pressure on healthcare systems and government budgets. In the U.S. today, roughly 28 million Americans have cardiovascular disease, 7 million people have dementia, and there are 1.9 million new cases a year —the three deadliest age-related diseases. By 2050, those numbers are projected to reach 184 million, 13.9 million, and an exponentially rising cancer burden with age, respectively.[1,2,3]

A population with poor health outcomes will drive increased spending on healthcare services and entitlement programs, such as pensions and Social Security. The cost of Medicare and Social Security are growing at a faster rate than our Gross Domestic Product due to our aging population. The Centers for Medicare & Medicaid Services project that National Health Expenditures will grow to $7.2 trillion by 2028.[4] Couple that with our shrinking working-age population due to persistently low fertility rates over the last few decades, and we're also poised to experience labor shortages and plummeting economic productivity. Japan reached this demographic situation in the early 1990s and currently has a smaller GDP than it did 30 years ago. The U.S. is approaching the precipice within the next decade. This aging demographic crisis is unprecedented in human history and thus, a completely novel, prevention-focused approach is needed to combat the consequences—one that emphasizes healthcare over sickcare.

The Development of "Longevity Biotechnology"

Modern medicine has made tremendous strides in treating acute illnesses, yet it remains largely unable to cure chronic, age-related diseases. This lack of progress can be largely attributed to two things. First, biomedical research (including drug development) and clinical practice are fundamentally reactive, waiting until people become sick before taking action. Second, these institutions have largely ignored the single greatest risk factor for—and mechanistic cause of—nine of the ten top killers in the United States: the biological aging process itself.

This reactive approach has led to increases in lifespan without a corresponding increase in healthspan—the period of life spent in good health. As a result, many Americans spend their

[1] Cancer Statistics Center. Accessed on June 30, 2024. https://cancerstatisticscenter.cancer.org/
[2] 2024 Heart Disease and Stroke Statistics: A Report of US and Global Data From the American Heart Association. Circulation. Volume 149, Issue 8, 20 February 2024; Pages e347-e913 February 20, 2024. Accessed on June 30, 2024. https://www.ahajournals.org/doi/epub/10.1161/CIR.0000000000001209
[3] Alzheimer's Facts and Figures. Accessed on June 30, 2024. https://www.alz.org/alzheimers-dementia/facts-figures
[4] National Health Expenditure Fact Sheet (2022). Accessed on June 01, 2024. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet

final decades burdened by multiple chronic conditions and a reduced quality of life, which places significant strain on families and the healthcare system. Even if all forms of cancer were cured, average life expectancy would only increase by about three years, because curing a single disease does not address the underlying aging processes that drive the development of all other age-related diseases.[5]

The longevity biotechnology industry has emerged from decades of research that has demonstrated that aging is malleable and can be modulated by environmental factors, lifestyle interventions, and therapeutic drugs that target the pathways of aging biology, resulting in increased healthy lifespan. There are hundreds of longevity biotechnology companies in the U.S. developing therapies that target aging, with dozens entering Phase II and III trials within the next few years.[6] Economists argue that the introduction of longevity medicine to society could drive substantial gains in GDP from increases in citizen productivity and decreases in costly end-of-life medical care. Even in the most conservative estimates, the U.S. stands to add trillions to its GDP from the addition of one year of average healthy life expectancy.[7] Furthermore, lifestyle and behavioral interventions—such as physical activity regimens, dietary modifications, and stress reduction—can synergize with these pharmacological approaches, underscoring the need for a broad "healthcare" model that prevents illness, not just treats it.

NIH's Lack of Focus on Longevity and Aging Research

The NIH has yet to shift its thinking from siloed, disease-specific efforts to research that advances the understanding and practical applications of the biology of aging. Currently, less than 1% of NIH funding is allocated to investigating and addressing the biology of aging—despite aging being the primary risk factor for 9 out of the 10 leading causes of death in the U.S. This represents a profound misallocation of federal resources. If the FY2026 budget is approved by Congress, which includes an $18 billion cut to NIH funding, this imbalance is expected to worsen.[8]

In a recent report to Congress, the NIH detailed its ongoing geroscience (the field connecting aging biology to health and disease) research efforts, but the report revealed that there is very little activity in this area and even less progress toward the development of new therapies

[5] Wu, S. (October 2023). USC Today: Delayed aging is better investment than cancer, heart disease research. Accessed on March 27, 2024. https://today.usc.edu/delayed-aging-is-better-investment-than-cancer-heart-disease-research/
[6] The Rejuvenation Roadmap. Accessed on June 30, 2024. https://www.lifespan.io/road-maps/the-rejuvenation-roadmap/
[7] Scott, A.J et al, The economic value of targeting aging. Nat Aging 1, 616–623 (2021). Accessed on June 30, 2024. https://doi.org/10.1038/s43587-021-00080-0
[8] https://www.whitehouse.gov/wp-content/uploads/2025/05/Fiscal-Year-2026-Discretionary-Budget-Request.pdf. Accessed on June 26, 2025.

targeting aging.[9] As we prepare for the consequences of our aging population, the NIH must shift its focus and invest heavily in translational research on interventions that will effectively address multiple age-related diseases at once, whether those interventions be pharmacological (e.g., new drugs) or non-pharmacological (e.g., targeted lifestyle changes).

Proposing The National Institute for Healthy Longevity and Aging Research (NIHLAR)

The Alliance for Longevity Initiatives (A4LI) proposes the establishment of a new institute, The National Institute for Healthy Longevity and Aging Research (NIHLAR), within the NIH to better reflect the healthcare and societal needs of our country. NIHLAR will streamline NIH efforts by coordinating research on aging's biological processes, improving efficiency and accountability, and unifying age-related disease studies. The NIHLAR Director, who should have terms of no more than 10 years, will be tasked with setting time-bound goals and measuring progress against those timelines. This approach aligns with Congress's vision for a more focused and responsive NIH to the needs of Americans. NIHLAR's mission is to extend the healthy lifespan of Americans from roughly 66 years (where it currently stands) to 85 years by 2045.

If the proposed NIH consolidation plan is enacted—reducing 27 institutes to 8—there is an opportunity to establish a dedicated institute focused on aging biology. Under this framework, Alzheimer's disease and related dementia research would likely remain primarily within the National Institute on Aging (where most funding currently supports AD) while also being spread across the new *National Institute on Neuroscience and Brain Research*. This restructuring would create space for NIHLAR to emerge as the central institute for geroscience and translational aging research. By moving beyond fragmented, disease-specific silos, NIH can elevate aging biology to the same level of visibility and funding as other major health priorities.

Divisions of NIHLAR (Extramural Research Grants)

The divisions of NIHLAR will reflect its goals of advancing translational research and fostering measurable health improvements for older adults and the broader population. While elements of these divisions overlap with existing NIA priorities, NIHLAR will refocus the research portfolio toward extending healthspan, accelerating clinical discoveries, and deploying real-world interventions that enable Americans to lead healthier, more productive lives as they age. In doing so, NIHLAR will adopt structural reforms that support high-risk, high-reward projects, ushering in the bold scientific advances that a modern NIH needs.

[9] Department of Health and Human Services. NIH Report on Geroscience. https://www.afar.org/imported/RTC-on-Geroscience_FINAL.signed.pdf

Division of Aging Biology (DAB)

The Division of Aging Biology (DAB) will concentrate on foundational research into the molecular, cellular, and genetic mechanisms that govern the aging process, with an emphasis on uncovering new therapeutic targets to delay or prevent age-related diseases.[10] Scientists within the DAB will explore the "hallmarks of aging"—such as cellular senescence, telomere attrition, proteostasis, and epigenetic regulation—to understand precisely how these mechanisms drive functional decline. This division will also maintain and develop advanced model systems and high-throughput screening platforms, ensuring that experimental discoveries move swiftly toward identifying and characterizing potential interventions. By pursuing bold, curiosity-driven research, the DAB will provide a robust pipeline of novel targets, drug candidates, and validated biomarkers that can be tested in clinical settings.

Within the DAB, a dedicated Biomarkers of Health, Function, and Aging (DBHFA) Task Force will focus on identifying and validating biomarkers that enable early diagnosis, prevention, and monitoring of aging and age-related diseases. By forming strategic public-private partnerships for longitudinal data collection, this Task Force will help establish baselines for normal aging, measure age-dependent biological changes in individual patients, and align biomarker development with regulatory requirements. These efforts will facilitate the approval and clinical adoption of innovative treatments targeting aging, ultimately guiding therapeutic decisions and monitoring treatment responses in older adults.

Division of Translational Longevity & Clinical Trials (DTLC)

The Division of Translational Longevity & Clinical Trials will translate fundamental discoveries into therapeutics and interventions to improve healthspan. In addition to collaborating closely with sectors in biotechnology, pharmaceutical, and academic partners, DTLC will design and oversee in-house trials for interventions that are unlikely to attract private-sector investment but show promise for substantially improving healthy longevity. This includes next-generation therapeutics targeting core aging pathways as well as lifestyle-based interventions with strong mechanistic underpinnings. By coordinating regulatory efforts with agencies like the FDA, developing clinical endpoints and surrogate endpoints tailored to therapies focused on aging, and ensuring that biomarkers from DBHFA are used to measure impact, DTLC will expedite the journey from bench to bedside. Its mission is to bring safe, evidence-based interventions—whether pharmaceutical, lifestyle, or a combination of both—into clinical practice for the benefit of all Americans.

Division of Population Health and Lifestyle Innovation (DPHL)

The Division of Population Health and Lifestyle Innovation (DPHL) will study social infrastructure and longevity trends, analyzing their impact on healthcare utilization, workforce

[10] National Institute on Aging Division of Aging Biology. Accessed on 8/03/2024. https://www.nia.nih.gov/research/dab

productivity, and public programs such as Medicare and Social Security. It will also quantify the potential "longevity dividend" and simulate its effects on GDP growth. In parallel, the division will explore how behavioral factors influence the adoption of healthy lifestyles and develop practical strategies to encourage prevention-focused decision-making. To translate insights into action, DPHL will collaborate with healthcare providers, community organizations, and technology companies to test and scale best practices in areas like diet, exercise, supplementation, and social engagement. It will assess how tools such as wearable health monitors, AI-driven diagnostics, telehealth, and smart-home systems can support older adults in proactively managing their health. By rapidly iterating on pilot programs in diverse communities and developing evidence-based recommendations—from personalized exercise plans to effective dietary patterns—DPHL will help integrate proven strategies into standard care. It will also advise federal and state policymakers on incorporating these lifestyle interventions and technologies into broader public health initiatives.

Rationale for the Divisional Breakdown

This organizational strategy avoids fragmenting research by narrow discipline and instead groups teams around pivotal goals—foundational discovery, translational science, societal impact, and near-term lifestyle implementation.[11] This organizational strategy avoids fragmenting research by narrow discipline and instead groups teams around pivotal goals—foundational discovery, translational science, societal impact, and near-term lifestyle implementation. The Division of Basic Aging Biology pursues essential insights into the underlying mechanisms of aging, providing a steady stream of targets and biomarkers that the Division of Translational Longevity & Clinical Trials rigorously tests and adapts for clinical use. The Division of Population Health and Lifestyle Innovation (DPHL) will lead research and real-world implementation efforts at the intersection of social infrastructure, economic policy, and behavioral science to improve healthy aging, quantify the longevity dividend, and scale lifestyle-based interventions and technologies that promote longer, healthier lives across diverse communities. By creating these three divisions, NIHLAR can meaningfully provide innovative tools to extend healthspan for millions of Americans, while simultaneously preventing the burden of chronic diseases and strengthening the nation's social and economic well-being.

It should be noted that there will be no division within the NIHLAR portfolio specifically focused on neurodegenerative research. Currently, eleven other NIH institutes fund neurodegenerative studies. We believe this research should either remain a core focus of the National Institute on Aging—historically the primary funder of Alzheimer's Disease and Related Dementias or be consolidated within the proposed National Institute on Neuroscience and Brain Research to better enable coordination and goal-setting around neurological and neurodegenerative diseases. In a future NIH reorganization, Alzheimer's disease research could

[11] National Institute on Aging Fiscal Year 2025 Budget. Accessed on August 10, 2024. https://www.nia.nih.gov/about/budget/fiscal-year-2025-budget#graphs

be fully grouped under that neuroscience-focused institute, allowing NIHLAR to concentrate exclusively on aging biology.

NIHLAR Budget

We recommend setting NIHLAR's budget on par with the National Cancer Institute's annual funding (currently around $7.22 billion) under the new Administration for a Healthy America (AHA) agency.[12] Aging is the single greatest risk factor for numerous chronic diseases—cancer, dementia, diabetes, and heart disease among them—so a bold, coordinated effort to address the biology of aging is essential to tackling America's most pressing health challenges. As part of its mandate, NIHLAR would consolidate and repackage all existing geroscience projects scattered across various institutes under one roof, creating synergy and accelerating breakthroughs. By funding NIHLAR at the same level as institutes devoted to single diseases, Congress would acknowledge that preventing the root causes of age-related conditions can reduce healthcare costs and improve outcomes far more effectively than tackling them one at a time. After all, if we're serious about ending the nation's "sick care" crisis, we must invest in solutions that match the size of the problem. And this is a big problem that demands an even bigger solution.

Strategic Coordination at NIHLAR

Coordination with other Age-Related Disease Institutes

Given aging's central role in driving diseases of aging, NIHLAR should serve as a hub for extensive collaboration with other agencies and institutes focused on age-related diseases. By fostering collaborations across various entities, NIHLAR aims to streamline research activities, maximize resource efficiency, and accelerate the development of new therapies. The biology of aging plays a crucial role in age-related diseases such as cancer, heart disease, dementia, kidney disease, and diabetes. By investigating the underlying mechanisms of aging, researchers can develop targeted therapies to prevent, mitigate, or cure multiple major age-related diseases. Therefore, we recommend mandating that both NIHLAR and age-related disease institutes (including but not limited to NCI, NHLBI, NIDCR, and NIAID), should they exist, make all relevant data available to each other, including longitudinal study data, genomic and phenomic data, biomarkers, imaging data, and clinical trial results.

Coordination with FDA

A significant challenge for longevity biotechnology companies is the lack of clarity on appropriate indication areas, approval pathways, clinical endpoints, and intermediate metrics of success. Conversely, efforts by the FDA to establish such pathways ahead of time, or to allocate specialized staff for emerging aging-related applications, would be highly beneficial in

[12] National Cancer Institute. Accessed on August 10, 2024. https://www.cancer.gov/about-nci/budget#what-is-ncis-current-fiscal-year-2024-fy24-budget

delivering the societal benefits envisioned by NIHLAR. We believe that part of NIHLAR's mission should involve coordinating with the FDA to develop appropriate biomarkers and metrics for companies entering clinical trials for therapies targeting aging, as well as approval pathways that acknowledge the potential multi-indication benefits of aging therapeutics. Such efforts must also consider the differing perspectives on popular yet controversial drugs—like GLP-1 agonists—by evaluating benefits and risks thoroughly without endorsing any single approach prematurely.

Congress should direct the FDA to collaborate with NIHLAR—specifically the Division of Aging Biology's Biomarkers of Health, Function, and Aging (DBHFA) Task Force and the Division of Translational Longevity & Clinical Trials (DTLC), and, where relevant, the Division of Lifestyle Innovation for Longevity (DLTIL)—to develop a plan to resolve these issues. This partnership will help ensure that new biomarkers, clinical endpoints, and approval pathways are aligned with both scientific discovery and regulatory requirements, accelerating the translation of aging research into clinical practice.

Accountability at NIHLAR

Accountability will be a cornerstone of NIHLAR's mission, ensuring that the institute operates with transparency, efficiency, and a clear focus on delivering measurable outcomes. Below, we propose NIHLAR's rigorous oversight mechanisms and set specific, public objectives to evaluate the effectiveness of its initiatives and the efficient allocation of resources.

Metrics to allocating NIHLAR grants

Reviewers should assign scores (1 = Exceptional, 9 = Poor) to each criterion, with optional strategic areas considered for added merit.

Evaluation Category	Criteria	What else does it resolve in this field?	Score (1-9)
1. Peer-review publication saturation vs. translational gap	High publication volume (>1,000 peer-reviewed results in the last 5 years) with minimal translational outcomes reduces priority; prioritize underexplored but promising areas	By incorporating publication saturation into funding decisions, the system shifts focus away from chasing high-impact journals toward supporting research areas with genuine translational potential. This approach discourages repetitive publishing in well-explored fields and reallocates resources to emerging, underserved topics with high	

		innovation value. Ultimately, it prioritizes real-world impact over journal prestige, helping reduce costly delays and frustration while promoting meaningful advances in healthy aging.	
2. Novelty in mechanism or concept	Novel biological targets; cross-disease relevance; beyond incremental discovery	Targeting newly discovered aging pathways Uncovering cross-disease aging signatures	
3. Technology & translational innovation	Tech-enabled methods; supports scalability and clinical relevance; includes real-world tools	Drives more tech innovation to help with translation: AI for biomarker development, wearables or digital phenotyping tools, new imaging, omics, or delivery platforms, regulatory or real-world data strategies	
4. Collaboration & reproducibility	Multi-institutional team; reproducibility focus; open science; diversity in collaborators	Note: Rather than dividing the total amount, structure it as: ● One **prime institution** ● Two **subcontracts** (with detailed scopes of work and smaller budgets)	
5. Clinical trial development path	Path to IND/public health application; milestones; clear endpoints; scalability potential	Integration with regulatory strategy (e.g., FDA, CMS) For non-interventional proposals: a realistic pathway to public health or clinical adoption	

Metrics to re-allocating NIHLAR grants

Guidance for Action Based on Total Score (Max = 30):

- 26–30 → Continue Funding (Full)
- 20–25 → Continue w/ Progress Conditions
- 14–19 → Pause / Partial Reallocation
- <14 → Recommend Discontinuation

Criterion	Description	Scoring Scale	Flag for Action
1. Scientific Progress	Progress made toward original aims as outlined in grant	1 = No progress 2=Minimal 3 = Moderate 4 = Strong 5 = Exceeded expectations	< 3 = Review for reallocation
2. Publication & Output Relevance	Evidence of peer-reviewed publications or translational products (e.g., protocols, data tools, IP, trial designs)	1 = None 2 = Marginal 3 = Adequate 4 = High-impact 5 = Landmark	1–2 = Reevaluate funding
3. Topic Saturation & Redundancy	Area shows high saturation (e.g., >1,000 papers in 5 yrs) with no novel contribution	1 = Duplicative 2 = Low novelty 3 = Some innovation 4 = New mechanism 5 = Groundbreaking	1–2 = Consider sunset
4. Translational Trajectory	Evidence that project is moving toward clinical, public health, or policy relevance	1 = No path 2 = Speculative 3 = Early steps 4 = Clear plan 5 = Pilot/clinical underway	< 3 = Require milestones
5. Collaboration & Reproducibility	Quality of coordination across teams/institutions; data sharing & rigor	1 = Isolated 2 = Nominal 3 = Adequate 4 = Integrated 5 = Exemplar	1–2 = Consider corrective action
6. Milestone Completion (if applicable)	For milestone-based awards: progress on agreed-upon benchmarks	1 = None 2 = Missed milestones 3 = Some met 4 = All met 5 = Exceeded	< 3 = Pause or restructure

Centers of Excellence on Aging Research

The NIA, like most other NIH institutes, sponsors several Centers of Excellence. While these centers have made valuable contributions, there is room for improvement in terms of creating synergy and meeting specific objectives. Under the Division of Aging Biology (DAB), these Centers of Excellence will be tasked with setting clear, measurable goals to enhance their impact

and ensure alignment with NIHLAR's mission of advancing aging research. Centers that fail to meet their objectives—and fail to justify their continued support via substantial contributions—will have their funding reallocated to other institutions. This includes the Nathan Shock Centers of Excellence, which were established to provide national leadership and research resources in the basic biology of aging, and the Claude D. Pepper Older Americans Independence Centers, which play a vital role in providing research and training opportunities for clinician-scientists, equipping them with the best practices for caring for individuals of advanced age.

Centers will also be required to incorporate training in aging-biology-focused therapeutics and biomarkers, to leverage and disseminate the translational advances coming out of NIHLAR. Collaborations with industry or industry-focused training programs will be created to encourage the development of new therapies based on research funded by NIHLAR.

Centers for Data and Biobanks

Under the oversight of the Biomarkers of Health, Function, and Aging (DBHFA) Task Force (within the DAB), NIHLAR will continue to support several data centers and biobanks. To ensure that their utility is maximized by the research community, each biobank will set clear, actionable goals regarding the volume and diversity of data collection. Any data centers or biobanks that cannot reach their self-imposed goals will be assessed for reallocation, and assessments will be made public. The data centers and biobanks to be housed under DBHFA's purview include the Intervention Testing Program, the Caenorhabditis Intervention Testing Program, the Aged Rodent Colonies, the Aged Rodent Tissue Bank, the Aging Cell Repository, the Non-Human Primate Tissue Bank, the Primate Aging Database, the AgingResearchBioBank, the NIA Aging Cell Repository, the Baltimore Longitudinal Study of Aging (BLSA) Biorepository, the Health, Aging, and Body Composition (Health ABC) Study Biobank, and the Long Life Family Study (LLFS) Biobank.

NIHLAR and NIH-Wide Suggested Reforms

To create a more efficient and responsive agency, we have identified four key areas for reform that will be integral to the success of NIHLAR. These reforms are designed to foster innovative research and promote transparency, reducing redundancy in both public and private longevity sectors. While these reforms will be a core part of NIHLAR, we recommend implementing them NIH-wide to facilitate developments across all realms of biotechnology.

SBIR Reform

By statute, 3.5% of the NIH research budget must be used to support small businesses through the SBIR and STTR programs. However, the majority of program managers do not have a private sector background, which should be required when reviewing grants for small businesses.

Furthermore, these programs are not structured in a way that reflects the reality of starting and running a small biotechnology company. The application process remains burdensome and slow, causing many eligible companies to refrain from applying for these grants and openly considering the SBIR and STTR programs as detrimental to their fundraising efforts.

We recommend that the NIH centralize its SBIR and STTR programs into a single office at the NIH and that funds be allocated proportionally based on the relative budgets of the institutes. If such consolidation cannot be achieved across the NIH, NIHLAR's Division of Translational Longevity & Clinical Trials (DTLC) should manage the SBIR and STTR programs. Improving these programs hinges on hiring dedicated program managers with private-sector experience to make award decisions. Additionally, these programs would benefit from a substantially reduced application burden on private sector applicants, who currently invest more effort for less funding compared to private capital sources. SBIR and STTR applicants are often academic researchers looking to commercialize their discoveries but lacking entrepreneurial experience, leading to a high failure rate for SBIR and STTR-funded companies. To address this, NIHLAR should fund, with remaining SBIR dollars, entrepreneurship training and accelerator programs for these funded researchers and provide expedited review consideration for scientists who have completed such programs.

Raising Standards for Grant Review Committees

NIH's peer review process has long faced criticism for favoring incremental advances over transformative research—a challenge that limits innovation and favors safer, narrower-scope projects. While the proposed centralization of all first-level peer review under the Center for Scientific Review (CSR) is expected to improve efficiency, reduce bias, and save over $65 million annually, it also presents an opportunity to reshape how scientific merit is assessed.[13] A4LI believes that Congress should direct NIH—and NIHLAR in particular—to ensure that centralized review processes include clear standards that actively reward high-risk, high-reward science and the development of cutting-edge technologies. Aligning peer review practices with bold, future-focused research priorities would help reinvigorate academic biology and unleash the creativity of researchers across the country.

Intramural Research Reform

The NIH Intramural Program (IRP) receives 10% of NIH funding and was established as a means for scientists to take risks and break new ground. Over time, however, it has functionally evolved into the equivalent of a university campus, where risk aversion often prevails and scientists stay for decades. That said, the IRP does feature outstanding successes—for example, NCI's Steve Rosenberg (father of immunotherapy) and Doug Lowy (inventor of the HPV

[13] https://www.nih.gov/news-events/news-releases/nih-centralizes-peer-review-improve-efficiency-strengthen-integrity. Accessed on June 26, 2025.

vaccine). Congress values the IRP, viewing it as the face of NIH. We therefore recommend softening criticisms but encouraging modernization.

A4LI urges the Committee to consider a wholesale reinvigoration of the NIH Intramural Program to ensure NIH campuses become places where scientists go to establish themselves professionally by pursuing groundbreaking research. Appointments should be limited in duration, and investigators should be incentivized to take risks that substantially advance their fields of study. The NIHLAR Intramural Research Program should be tied to the NIH Clinical Center and promote research that breaks new ground in longevity and aging. NIHLAR can leverage its intramural branch to pilot bold, high-reward initiatives that push the boundaries of geroscience, including synergy with potential lifestyle-based interventions as well as new pharmaceuticals.

Scientific Reproducibility and Publicizing Negative Results

Under the Division of Aging Biology (DAB), NIHLAR will develop a clear strategy for reproducing research findings to verify their validity and reduce the waste of time and resources. This reproducibility strategy should be made public, and annual findings should be publicly available for all reproducibility grants. Additionally, DAB will create a public archive for negative research results and require all NIHLAR-funded scientists to publish these findings. By making negative results readily available, the program will help reduce wasted resources and accelerate the development of effective treatments through a more comprehensive understanding of what does and does not work.

Concluding Call to Action

As the urgency of our aging population crisis grows day by day, the time has come for Congress to establish an agency focused directly on researching and developing therapeutics that target the biology of aging to ameliorate multiple age-related diseases at once—The National Institute for Healthy Longevity and Aging Research (NIHLAR). By centering on the trunk of the tree—aging biology itself—rather than treating each branch (disease) in isolation, we can significantly increase healthy lifespan, reduce the portion of life spent in poor health, and lessen the economic strain on Medicare and Social Security.

NIHLAR aligns well with proposals to streamline NIH, possibly decreasing the overall number of ICs by consolidating disease-specific work into broader institutes. In this vision, Alzheimer's disease and other dementia research might be grouped within a unified National Institute of Neuroscience, while geroscience forms the core of NIHLAR's mission. The breakthroughs that NIHLAR could fund—from interventions that slow cellular aging to lifestyle programs that keep older Americans active and engaged—have the potential to transform public health by extending healthy lifespans, improving quality of life, and easing the economic burden of an aging

population. This initiative also reflects Congress's broader goals for making the NIH more accountable and responsive.

A4LI urges policymakers, stakeholders, and the public to support NIHLAR and take decisive action to secure a healthier, more prosperous future for all Americans—before the demographic and healthcare expenditure challenges become insurmountable. By emphasizing prevention ("healthcare") rather than reaction ("sickcare"), NIHLAR can help the United States achieve a true longevity dividend, spurring higher workforce intergenerational productivity, lowering government expenditures on end-of-life care, and improving citizens' health and quality of life as they age.