AANA
American Association of
NURSE ANESTHESIOLOGY

February 27, 2026

Honorable Nicholas Kent
Under Secretary of Education
U.S. Department of Education
Submitted electronically via: regulations.gov

RE: Docket ID ED–2025–OPE–0944

Under Secretary Kent,

On behalf of the more than 69,000 members of the American Association of Nurse Anesthesiology (AANA), we write to you regarding the definition of professional degree in the Reimagining and Improving Student Education proposed rule. We urge the Department of Education (ED) to include post-baccalaureate nursing degrees as professional degrees in the final rule due to the critical importance of a robust advanced practice nursing workforce (e.g. MSN, DNP, DNAP, PhD).

Specifically, we urge you to include the nurse anesthesia profession in the definition of professional degree in the final rule (DNP, DNAP). The exclusion of future CRNAs from this definition not only contradicts statute, but exclusion from the higher student loan cap will have a devastating impact on future nurse anesthetists, their ability to afford nurse anesthesia programs, and exacerbate access gaps to essential healthcare among patients with the greatest barriers.

AANA is the professional association representing Certified Registered Nurse Anesthetists (CRNAs) and Student Registered Nurse Anesthetists (SRNAs) nationwide. CRNAs are Advanced Practice Registered Nurses (APRNs) who are doctorally prepared autonomous anesthesia providers through their training and preparation. CRNAs must be board certified and participate in continuing education and recertification every 4 years in order to practice. CRNAs provide expert anesthesia and pain management care across diverse clinical settings and are trained and licensed to care for all patients, including those with complex medical conditions. In some states, CRNAs are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

For the following reasons, CRNAs should be categorized as professional students seeking professional degrees and therefore qualify for the student loan cap of $50,000 per year or $200,000 in aggregate.

I. **CRNAs are highly educated and clinically trained to independently practice the licensure-required profession of nurse anesthesia and due to the rigor of CRNA programs they carry high necessary costs.**
II. **CRNAs are wrongfully excluded from the proposed regulatory definition in direct contradiction of statute, which cited 34 CFR § 668.2, and in direct contradiction of the RISE Committee stakeholder proposed definition which properly used the building blocks of 34 CFR § 668.2 while providing appropriate operational clarity.**
III. **ED's proposed definition improperly changes statutory text by making the illustrative list in § 668.2 exhaustive yet adding clinical psychology and ED's analysis excluding advanced practice nursing from the professional degree definition incorrectly conflates the practice of nurse anesthesia with registered nursing.**
IV. **CRNAs meet the intention behind the student loan cap provisions of the One Big Beautiful Bill Act as the nurse anesthesia profession is a high return on investment.**
V. **Misclassifying future CRNAs in the final rule will cripple the CRNA workforce pipeline, deepening anesthesia care access gaps for rural and underserved communities.**

These comments will cover background on CRNA preparation, the field of nurse anesthesia, and the reasons why CRNAs were originally included in the statutorily required definition of professional degree, as well as why CRNAs meet the congressional intent behind these provisions due to their high return on investment. We also believe it is important to stress the downstream impacts of misclassifying future CRNAs as graduate students, therein imposing a student loan cap that will block access to these programs for many potential applicants and cause a bottleneck to an essential healthcare workforce. This impact will be felt by patients in rural and underserved areas the most at a time when the anesthesia workforce is already facing a critical shortage.

I. CRNAs are highly educated and clinically trained to independently practice the licensure-required profession of nurse anesthesia, and due to the rigor of CRNA programs, they carry high necessary costs.

CRNAs must earn a doctorate degree, either a Doctor of Nursing Practice (DNP) or Doctor of Nurse Anesthesia Practice (DNAP), from a Council on Accreditation of Nurse Anesthesia Educational Programs (COA) accredited program. These programs range from 3 to 4 years in length. COA's standards require these DNP or DNAP programs to be rigorous in didactive and clinical experience in order to prepare SRNAs for immediate autonomous practice of anesthesia.[1] COA requires at least 2,000 clinical hours "in the actual

[1] Council on Accreditation of Nurse Anesthesia Educational Programs, *Standards for Accreditation of Nurse Anesthesia Programs: Practice Doctorate*, Effective January 1, 2026, available at:

administration of anesthesia" for these programs.[2] Applicants to a CRNA program must currently hold a nursing degree, a registered nursing license in good standing and have at least one year of experience in critical care nursing. They are the only anesthesia professionals that must have critical care experience before they begin their anesthesia education. Upon graduation, SRNAs must pass the National Certification Examination (NCE) administered by the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA) to gain their nurse anesthesia license.[3] CRNAs must complete recertification every four years to maintain this licensure.[4] CRNAs can attend a post-graduate fellowship to specialize in pediatric or pain management care.[5] Additionally, many CRNA faculty go on to earn their PhD in critical areas such as Pharmacogenomics, the study of how genetic variations affect patient reactions to medications.

Doctoral degrees are required for entrance into the nurse anesthesia profession as of 2025.[6] The move from master's preparation to doctoral preparation has been a continuation of the AANA and COA collaborative process to ensure CRNAs are the best-prepared and safest anesthesia providers.[7] As advancements in care and the entire healthcare environment change rapidly, providers must rise to the challenge by expanding their knowledge base and skill sets. A doctoral program ensures that CRNAs are integrating the latest technological and pharmaceutical advances, informatics, evidence-based practice, systems approaches to quality improvement, healthcare business models, teamwork, public relations, and other emerging areas into their preparation.

Due to the rigor and intensity of CRNA doctoral programs, they carry heavy tuition costs. Programs must purchase cutting edge equipment for training SRNAs in real world-like environments, extensive malpractice insurance due to the high rate of litigation in the anesthesia field, competitive pay for high-quality faculty, and they require vast administrative support to ensure clinical training sites and contracts. Physician anesthesiologist programs also carry these costs as anesthesia practice uses the same equipment and methods. Yet, CRNA education does not receive funding from the almost

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https://www.coacrna.org/wp-content/uploads/2025/08/Standards-for-Accreditation-of-Nurse-Anesthesia-Programs-Practice-Doctorate-May-2025-Effective-Date-January-2026-1.pdf.

[2] Council on Accreditation of Nurse Anesthesia Educational Programs, *Guidelines for Counting Clinical Experiences*, Revised January 2026, available at: https://www.coacrna.org/wp-content/uploads/2026/01/Guidelines-for-Counting-Clinical-Experiences-Jan-2026.pdf

[3] https://www.nbcrna.com/students/nbcrna-certification

[4] National Board of Certification & Recertification for Nurse Anesthetists, *The Continued Professional Certification (CPC) Program*, available at: https://www.nbcrna.com/certification-programs/cpc

[5] Council on Accreditation of Nurse Anesthesia Educational Programs, *List of Accredited Fellowships as of December 5, 2025*, available at: https://www.coacrna.org/wp-content/uploads/2025/12/List-of-Accredited-Fellowships-December-5-2025.pdf.

[6] Council on Accreditation of Nurse Anesthesia Educational Programs, *Standards for Accreditation of Nurse Anesthesia Programs: Practice Doctorate*, Effective January 1, 2026, available at: https://www.coacrna.org/wp-content/uploads/2025/08/Standards-for-Accreditation-of-Nurse-Anesthesia-Programs-Practice-Doctorate-May-2025-Effective-Date-January-2026-1.pdf

[7] American Association of Nurse Anesthesiology, *AANA Position on Doctoral Preparation of Nurse Anesthetists*, Adopted June 2, 2007, on file with AANA.

$22 Billion in federal funds that goes in to Graduate Medical Education (GME) annually.[8] Unlike physician anesthesiology programs, who are able to utilize this GME money to pay their residents, SRNAs are often unpaid during their clinical training and heavily rely on student loans for supplies and living expenses. CRNA programs can cost over $100,000 in tuition alone. There can be differences between in state and out of state tuition, such as at University of Tennessee where the in-state tuition and fees cost $19,723 per year and out of state is $45,474.[9] However, there are just over 150 CRNA programs in the U.S., but not every state has a college or university that offers them. Specifically, students from Alaska, New Hampshire, Vermont, and Wyoming must seek their CRNA education and training outside their state of residence.

These factors cause the average CRNA to graduate with more than $200,000 in debt, necessitating the professional degree cap.[10] Additionally, according to the data ED includes in Table 5.3, 45.2 percent of nurse anesthetist borrowers had annual loans above $50,000 in the 2023-2024 year.[11] This closely follows the 49 percent of borrowers in medicine who have annual loans above $50,000 as both these fields demand programs with high costs. As the proposed rule includes MD and DO degrees as professional but misclassifies nurse anesthesia, this will exacerbate the already anticompetitive anesthesia provider education system by further disadvantaging SRNAs.

II. CRNAs are wrongfully excluded from the proposed regulatory definition in direct contradiction of statute, which cited 34 CFR § 668.2, and in direct contradiction of the RISE Committee stakeholder proposed definition which properly used the building blocks of 34 CFR § 668.2 while providing appropriate operational clarity.

A. The One Big Beautiful Bill Act, enacted on July 4, 2025, required professional degrees to be defined as written in 34 CFR § 668.2 which includes requirements DNP/DNAP degrees meet, and includes an illustrative list of professional degrees stating professional degrees "include but are not limited to" this list, clearly indicating the list was not meant to be exhaustive.

This proposed rule seeks to implement the change in statute. As the One Big Beautiful Bill Act states, "…the term 'professional student' means a student enrolled in a program of

[8] Government Accountability Office, *Graduate Medical Education: Information on Initial Distributions of New Medicare-Funded Physician Residency Positions*, December 22, 2025, available at: https://www.gao.gov/products/gao-26-107686.
[9] University of Tennessee Health Science Center, *Tuition Information (2025-2026*), available at: https://uthsc.edu/finance/bursar/fees/index.php.
[10] CRNA Financial Planning, *A CRNA's Life After Anesthesia Preview: Chapter 1 the Current Landscape in Health Care for CRNAs*, available at: https://www.crnafinancialplanning.com/p/a-crnas-life-after-anesthesia-chapter-1-preview.
[11] Reimagining and Improving Student Education, 91 Fed. Reg. 4254, 4316 (January 30, 2026).

study that awards a professional degree, as defined under section 668.2 of title 34, Code of Federal Regulations (as in effect on the date of enactment of this paragraph), upon completion of the program."[12]

The code defines a professional degree in three parts. First, it requires a professional degree to be, "A degree that signifies both completion of the academic requirements for beginning practice in a given profession and a level of professional skill beyond that normally required for a bachelor's degree." Second, it states, "Professional licensure is also generally required." Finally, section 668.2 gives a non-exhaustive list of degrees that would meet these requirements. It states, "Examples of a professional degree **include but are not limited to** Pharmacy (Pharm.D.), Dentistry (D.D.S. or D.M.D.), Veterinary Medicine (D.V.M.), Chiropractic (D.C. or D.C.M.), Law (L.L.B. or J.D.), Medicine (M.D.), Optometry (O.D.), Osteopathic Medicine (D.O.), Podiatry (D.P.M., D.P., or Pod.D.), and Theology (M.Div., or M.H.L.)."[13]

CRNA programs squarely meet this definition. A DNP/DNAP degree prepares SRNAs academically for independent practice of the nurse anesthesia profession. These programs ensure graduates have extensive clinical training in nurse anesthesia at the doctoral level which is a professional skill well beyond what can be achieved at the bachelor's degree level. Finally, CRNAs must be licensed by NBCRNA in order to practice their profession. The DNP/DNAP degree aligns with the other health professions listed in Classification of Instructional Program (CIP) code 51 as examples in 668.2 as they all require the highest level of academic and clinical preparation in their respective pathways to licensure. This analysis dictated in 668.2 was clearly intended to be the definition by Congress as OBBBA explicitly cites 668.2 "as in effect on the date of enactment of this paragraph." This is confirmed in Senate Health, Education, Labor, and Pensions Committee FAQs.[14]

Additionally, the Integrated Postsecondary Education Data System (IPEDS), which is the ED-run survey system that collects data required by the Higher Education Act on any institution participating in federal student aid programs including the types of degrees awarded, instituted a new classification of professional degrees in the 2010-2011 data collection. Replacing the term "first-professional degree" is now three options: "doctor's degree—research/scholarship," "doctor's degree—professional practice," and "doctor's degree—other." The IPEDS glossary defines a "doctor's degree – professional practice" as "A doctor's degree that is conferred upon completion of a program providing the knowledge and skills for the recognition, credential, or license required for professional practice. The degree is awarded after a period of study such that the total time to the degree, including both pre-professional and professional preparation, equals at least six

[12] One Big Beautiful Bill Act, Pub. L No. 119-21, Sec. 81001, 139 Stat. 72, 335 (2025).
[13] 34 CFR § 668.2
[14] Senate Committee on Health, Education, Labor, and Pensions, *Q & As About Higher Education in the One Big Beautiful Bill*, August 1, 2025, available at: https://www.help.senate.gov/imo/media/doc/faq_docpdf1.pdf.

full-time equivalent academic years."[15] CRNA programs squarely fit this definition as they award doctoral degrees that provide the education and clinical skills for the licensed practice of nurse anesthesia. The period of study for this profession, including undergraduate preparation, is at least seven full time academic years.

The IPEDS glossary definition goes on to explain "doctor's degree-professional practice" as, "Some of these degrees were formerly classified as first-professional and **may** include: Chiropractic (D.C. or D.C.M.); Dentistry (D.D.S. or D.M.D.); Law (J.D.); Medicine (M.D.); Optometry (O.D.); Osteopathic Medicine (D.O); Pharmacy (Pharm.D.); Podiatry (D.P.M., Pod.D., D.P.); or, Veterinary Medicine (D.V.M.), **and others, as designated by the awarding institution**."[16] Matching section 668.2, the IPEDS classification also includes an illustrative and non-exhaustive list. Additionally, IPEDS data pulled by the Reimagining and Improving Student Education (RISE) Committee stakeholders shows that 71.7 percent of nurse anesthetist doctoral degrees are reported as "doctor's degree - professional practice."[17]

The definition ED was given by Congress to implement recognizes that professional fields are constantly evolving. This is especially true in healthcare. The healthcare workforce today is remarkably different from even just 30 years ago due to advancements in care and education. CRNAs match the requirements designated in statute and are wrongfully excluded in ED's proposed rule.

B. CRNA programs also meet the requirements of the RISE Committee stakeholder definition that used the building blocks of 34 CFR § 668.2 while appropriately adding clarity for operationality.

The Reimagining and Improving Student Education (RISE) Committee had extensive discussion on the definition of professional degree during the negotiated rulemaking process of this proposed rule. The stakeholder definition reiterated that OBBBA requires the illustrative list of degrees to be non-exhaustive and inferred the reasonable interpretation that Congress intended to include any fields within the two-digit CIP code of the fields in the illustrative list. The stakeholder definition distilled this into a three-part test: (1) is the degree program in the illustrative list; (2) is the degree program in an adjacent field and of similar length of the fields in the illustrative list; and (3) are there any exceptions that Congress believed would have been included under the adjacent field test that were left out?

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[15] National Center for Education Statistics, IPEDS Data Collection System 2022-2023, *Glossary: Doctor's degree—professional practice*.
[16] National Center for Education Statistics, IPEDS Data Collection System 2022-2023, *Glossary: Doctor's degree—professional practice*.
[17] RISE Committee, *Memo on a Revised Professional Degree Definition and Aligning Definitions in the Code of Federal Regulations*, October 10, 2025, available at: https://www.ed.gov/media/document/2025-rise-memo-revised-professional-degree-definition-and-aligning-definitions-code-of-federal-regulations-10102025-submitted-alex-holt-and-andrew-gillen.

The stakeholders on the committee compromised on the definition they presented to ED to ensure it honored the requirements of statute and the Congressional intention of ensuring return on investment for future student borrowers while giving specificity to address operationality.[18] The stakeholders rightly argued that OBBBA does not allow a replacement of section 668.2 but would allow addition of language that provides instructions on a test to satisfy its core requirements.[19] This also ensures that ED does not now have conflicting definitions of professional degree in separate sections of the Code of Federal Regulations.

As well as meeting the original text of section 668.2, CRNAs clearly meet the stakeholder definition. CRNA programs are listed in CIP code 51: Health Professions and Related Programs along with other fields listed in the illustrative list of 668.2. CRNA programs are substantially similar in length and field of study as they are three-to-four-year full-time doctoral level programs that regularly are at least 80 credit hours and prepare graduates for immediate practice in nurse anesthesiology.

For the third part of the test proposed by the stakeholders, they analyzed IPEDS data to find how many doctoral degrees are reported by institutions as "doctor's degree – professional practice." This analysis looked at the six-digit CIP code level and found all doctoral degrees with at least half reported to be "doctor's degree – professional practice" would have been included under the adjacent field test, as they would have fallen into the two-digit CIP code of a field in the illustrative list. The only exception was clinical psychology which IPEDS data showed had 57.8 percent of degrees reported as "doctor's degree – professional practice." Stakeholders concluded this category should be specifically written in to align with the data and congressional intent as it did not appear in any adjacent filed at the two-digit CIP code level.

Using this same rational, and as stated above, IPEDS data shows that 71.7 percent of nurse anesthetist doctoral degrees are reported as "doctor's degree - professional practice" and clearly should be included as professional degrees.[20] This high percentage is no surprise as CRNA programs emphasize practical learning and require at least 2,000 clinical hours in order to prepare students for immediate practice of their profession.

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[18] RISE Committee, *Revised proposed definition of professional degree submitted by Alex Holt, Andrew Gillen, Ashley Naporlee, and Tamar Hoffman*, October 10, 2025, available at: https://www.ed.gov/media/document/2025-rise-revised-proposed-definition-of-professional-degree-10102025-submitted-alex-holt-andrew-gillen-ashely-naporlee-and-tamar-hoffman-112553.pdf.

[19] RISE Committee, *Memo on a Revised Professional Degree Definition and Aligning Definitions in the Code of Federal Regulations*, October 10, 2025, available at: https://www.ed.gov/media/document/2025-rise-memo-revised-professional-degree-definition-and-aligning-definitions-code-of-federal-regulations-10102025-submitted-alex-holt-and-andrew-gillen.

[20] RISE Committee, *Memo on a Revised Professional Degree Definition and Aligning Definitions in the Code of Federal Regulations*, October 10, 2025, available at: https://www.ed.gov/media/document/2025-rise-memo-revised-professional-degree-definition-and-aligning-definitions-code-of-federal-regulations-10102025-submitted-alex-holt-and-andrew-gillen.

III. ED's proposed definition improperly changes statutory text by making the illustrative list in § 668.2 exhaustive yet adding clinical psychology and ED's analysis excluding advanced practice nursing from the professional degree definition incorrectly conflates the practice of nurse anesthesia with registered nursing.

A. ED fundamentally and improperly changes statutory text by making the illustrative list at 668.2 exhaustive and adding the field of clinical psychology to that exhaustive list yet excludes nurse anesthesia which meets all the core requirements.

ED argued the stakeholder definition would allow too much federal spending as it only limited fields at the two-digit CIP code level when identifying a "substantially similar" field to the illustrative list in section 668.2. ED's definition is instead is a four-part test: (1) Signifies both completion of the academic requirements for beginning practice in a given profession, and a level of professional skill beyond that normally required for a bachelor's degree; (2) is generally at the doctoral level, and that requires at least six academic years of postsecondary education coursework for completion, including at least two years of post-baccalaureate level coursework; (3) generally requires professional licensure; and (4) includes a four-digit program CIP code, as assigned by the institution or determined by the Secretary, in the same intermediate group as the fields in the illustrative list of section 668.2. However, ED added the field of clinical psychology (Psy.D. or Ph.D.) to that illustrative list from section 668.2. Under the current definition in the proposed rule, only degrees in the 11 fields, now including clinical psychology, will be categorized as professional.

As stated above, CRNA programs meet the core requirements of all definitions but under ED's proposed definition are disqualified because of the technicality of being listed within the same two-digit CIP code of the illustrative list of fields, but not within the four-digit level. ED seems to have taken to heart the RISE stakeholder argument that clinical psychology was meant to be included as it fits the core requirements also and awards more than half of degrees in the IPEDS category of "doctor's degree – professional practice." Yet CRNA programs award more degrees in the category of "doctor's degree – professional practice" than clinical psychology. CRNA programs carry higher necessary costs, similar to our physician anesthesiologist colleagues, and need access to the higher cap whereas clinical psychology would not be as heavily impacted at the lower cap. The inclusion of clinical psychology in an exhaustive list of section 668.2 fields without the operational structure provided in the stakeholder definition improperly deviates from statute.

It is clear that a main congressional intent in OBBBA was to reduce overborrowing in fields that are not a return on investment. ED's definition attempts to honor this intent by not allowing the inclusion of too broad an array of degrees that federal spending would be too high. ED mentions in the proposed rule that nursing is a field with heavy borrowing.

However, as explained further below in section IV, advanced nursing degrees show a substantial return on investment. CRNAs in particular are the clearest return on investment. The final rule must include a definition that reflects OBBBA's requirement for a non-exhaustive illustrative list and the congressional intent for return on investment. This requires including the nurse anesthesia profession.

B. ED relies on a flawed analysis that excludes advanced practice nursing degrees from the professional degree definition as this analysis conflates the practice of registered nursing and advanced practice registered nursing which incorrectly assumes that the distinct profession of nurse anesthesia is the same as registered nursing.

The practice of anesthesia, whether from nursing preparation or medical preparation, utilizes the same methods and standards of care.[21] While CRNAs are educated and trained in nursing, they practice the entirely distinct profession of anesthesia. ED conflates the practice of registered nurses (RN) and advanced practice registered nurses (APRN) in their analysis on why post-baccalaureate nursing degrees should not be classified as professional.[22] An RN, while critical to patient care and outcomes across the healthcare system, does not practice anesthesia care. They are not educated, trained, or licensed to do so. A CRNA does start their career as an RN with vital critical care experience. However, after completing their anesthesia education, clinical training, and licensure, they now practice an entirely different field and are qualified to practice across the perianesthesia continuum.

ED argues in the proposed rule that practice authority differences in state law disqualifies APRNs from being classified as distinct professions from RNs. CRNAs have no physician supervision requirements in 44 states.[23] Remaining outdated supervision requirements are not evidence-based and do not protect patients. There is overwhelming evidence that CRNAs practicing autonomously are safe and effective providers. When looking at anesthesia related complications between a CRNA-only model, a physician anesthesiologist-only model, and a team-based model, a peer-reviewed study in the Journal of Medical Care found no differences based on model.[24] A comprehensive

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[21] American Association of Nurse Anesthesiology, *Scope of Nurse Anesthesia Practice*, available at: https://issuu.com/aanapublishing/docs/scope_of_nurse_anesthesia_practice_2.23?fr=sNDg2MDU2NDAxMjU.

[22] Reimagining and Improving Student Education, 91 Fed. Reg. 4254, 4265 (January 30, 2026).

[23] There are no physician supervision requirements for CRNAs in state nursing laws or rules in the following states: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin, Wyoming.

[24] Negrusa B., et al., *Scope of practice laws and anesthesia complications: No measurable impact of certified registered nurse anesthetist expanded scope of practice on anesthesia-related complications*, Medical Care,

literature review on anesthesia staffing models completed by the Cochrane Library further reinforced these findings and found that there could be no definitive statement made about the superiority of any one anesthesia delivery model with respect to safety or adverse outcomes.[25] As CRNA programs prepare students to independently practice the profession of nurse anesthesiology, and continue to produce safe effective providers, ED must classify CRNAs as distinct from RNs.

Finally, ED concludes their disqualification of the nursing profession by stating that the statute would not allow inclusion of a profession where the degree leads to employment in which the employee is supervised by another professional "who has, as required by their license and degree, more education, training, and qualifications than the person being supervised."[26] This again misunderstands the nurse anesthesia profession. CRNAs are prepared for autonomous practice. When it comes to healthcare education, training, and direct patient care, CRNAs and physician anesthesiologists both spend 8 years on parallel tracks to becoming anesthesia providers.[27] Physicians can have an undergraduate degree in a field unrelated to healthcare while CRNA preparation is entirely rooted in the healthcare field. Physician anesthesiologists and CRNAs share the profession of anesthesiology but are prepared via either the nursing or medicine path. They both provide the same methods and are held to the same standards of care. They are both prepared to treat all patients, including those with co-morbidities or chronic conditions.

ED cannot use this argument to disqualify CRNAs from the professional category as they are not RNs and practice a completely different profession from RNs. Also, the argument that supervision by another professional is required for CRNAs is not accurate and was never a part of the analysis for entrance into the professional category required by statute nor during the RISE Committee negotiations. We urge ED to correct these mistakes in the preamble of the final rule.

IV. CRNAs meet the intention behind the student loan cap provisions of the One Big Beautiful Bill Act as the nurse anesthesia profession is a high return on investment.

Congress made clear that the student loan provisions passed in OBBBA were intended to address rising higher education costs and ensure a return on investment for students and

June 2016, available at http://journals.lww.com/lww-medicalcare/Abstract/publishahead/Scope_of_Practice_Laws_and_Anesthesia.98905.aspx.

[25] Lewis SR, et al., *Physician anesthetists versus non-physician providers of anesthesia for surgical patients*, Cochrane Database of Systematic Reviews, July 2014, available at: https://pubmed.ncbi.nlm.nih.gov/25019298/.

[26] Reimagining and Improving Student Education, 91 Fed. Reg. 4254, 4265 (January 30, 2026).

[27] American Association of Nurse Anesthesiology, *The Spin vs. the Facts: CRNA Education*, available at: https://www.aana.com/wp-content/uploads/2023/07/CRNA-MDA-Education-Infographic.pdf.

federal dollars.[28] During the RISE Committee's negotiations, Under Secretary Kent affirmed these provisions are to address the concern with "…programs that do not provide appropriate return on investment."[29] Under Secretary Kent stated that "…40% of master's degrees are not paying off for students."[30] ED argues in the proposed rule that the loan limits will help remove the number of "…degree programs that result in low earnings relative to the prices institutions charge."[31] ED also cites a study from the Foundation for Research on Equal Opportunity (FREOPP) in the proposed rule that found "approximately 43 percent of master's degrees and 23 percent of doctoral and professional degrees do not increase students' earnings enough to justify the costs of those programs."[32] However, the study itself acknowledges that breaking data down by field of study is important as aggregated data show master's degrees to be a poor return, but specifically master's degrees in nursing held a particularly strong return on investment.[33]

Nurse anesthesia programs are a high and stable return on investment. While publicly available data does not breakdown by field of study far enough to calculate nurse anesthesia DNP and DNAP programs specifically, the FREOPP study calculates that a doctoral degree in nursing from Texas Christian University (TCU) gives over a $4 million return on investment assuming on time graduation and an over $3.8 million return when calculating for risk of dropping out.[34]

Evidence from CRNA programs continue to prove this return for future CRNAs. The NCE pass rate for first time candidates was 90.5% in 2025 because these programs are highly competitive.[35] Programs regularly report 100% employment rates either upon or within 6 months of graduation, including the DNAP program at TCU.[36] U.S. News reports a 1.9% unemployment rate for CRNAs and gives it a high ranking for upward mobility.[37] Bureau of

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[28] Senate Committee on Health, Education, Labor, and Pensions, *Myth v. Fact: Higher Education in the One Big Beautiful Bill*, August 1, 2025, available at: https://www.help.senate.gov/imo/media/doc/myth_vs_fact_doc.pdf.
[29] RISE Committee, Transcript from Thursday November 6, 2025 AM, page 21, available at: https://www.ed.gov/media/document/2025-rise-transcript-thurs-11-6-am-112570.pdf.
[30] RISE Committee, Transcript from Thursday November 6, 2025 AM, page 21, available at: https://www.ed.gov/media/document/2025-rise-transcript-thurs-11-6-am-112570.pdf.
[31] Reimagining and Improving Student Education, 91 Fed. Reg. 4254, 4299 (January 30, 2026).
[32] Reimagining and Improving Student Education, 91 Fed. Reg. 4254, 4299 (January 30, 2026).
[33] The Foundation for Research on Equal Opportunity, *Does College Pay Off? A Comprehensive Return on Investment Analysis*, available at: https://freopp.org/whitepapers/does-college-pay-off-a-comprehensive-return-on-investment-analysis/#is-graduate-school-worth-it.
[34] The Foundation for Research on Equal Opportunity, *Is Grad School Worth It?,* available at: https://freopp.org/roi-in-higher-education/roi-graduate/.
[35] National Board of Certification & Recertification for Nurse Anesthetists, *Annual NCE and SEE Report: Calendar Year 2025*, available at: https://www.nbcrna.com/docs/default-source/publications-documentation/annual-reports/nbcrna-annual-nce-and-see-report-2025.pdf?sfvrsn=80325e7_2.
[36] Texas Christian University, *Harris College: School of Nurse Anesthesia*, available at: https://harriscollege.tcu.edu/nurse-anesthesia/index.php.
[37] U.S. News & World Report, *Nurse Anesthetist*, available at: https://careers.usnews.com/best-jobs/nurse-anesthetist.

Labor Statistics (BLS) data for 2024 shows a national annual mean wage of $231,700.[38] Due to the high employment availability and wages for CRNAs, they have an extremely low student loan default rate. AANA surveyed a sample pool of programs who reported 0 to 1 percent default rates for 2024 which is the period after the COVID-19 payment pause was lifted.

Nurse anesthesia is in the top 10 largest programs of borrowing according to the 2023–2024-year NSLDS data in Table 5.3 of the proposed rule.[39] However, nurse anesthesia would only be a modest increase at $194 million compared to $336 million for clinical psychology.[40] As Under Secretary Kent continued to emphasize during the RISE Committee negotiations, the intent behind these caps in OBBBA is to target programs with a poor return on investment. Not only do CRNAs yield exponential returns through expanded care access in rural areas and use of more efficient anesthesia care team models, nurse anesthesia programs, with nearly zero percent unemployment and graduates making over $230,000 a year, are exactly the kind of program OBBBA intended to support.

V. Misclassifying future CRNAs in the final rule will cripple the CRNA workforce pipeline, deepening anesthesia care access gaps for rural and underserved communities.

The country faces a widening anesthesia provider shortage that is predicted to continue, and the proposed rule's misclassification will only exacerbate this issue.[41] Compounding this shortage is aging populations needing more surgical services right as a large portion of physician anesthesiologists are expected to retire by 2030.[42] Additionally, BLS data predicts only a 3% growth in physician anesthesiologists by 2034.[43] In contrast, the CRNA workforce is growing while leading innovative practice strategies and efficient models of care. BLS data estimates a 9% growth in the CRNA workforce by 2034.[44] In 2025, 3,235 CRNAs entered the profession, up from 2,866 in 2024.[45] More and more communities and

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[38] Bureau of Labor Statistics, *Occupational Employment and Wage Statistics: Nurse Anesthetists, National, Annual Mean Wage*, May 2024, available at: https://data.bls.gov/oes/#/home.
[39] Reimagining and Improving Student Education, 91 Fed. Reg. 4254, 4316 (January 30, 2026).
[40] Reimagining and Improving Student Education, 91 Fed. Reg. 4254, 4316 (January 30, 2026).
[41] Negrusa et al., *Anesthesia Services: A Workforce Model and Projections of Demand and Supply*, Nursing Economic$, December 2021, available at: https://www.researchgate.net/publication/357569422_Anesthesia_Services_A_Workforce_Model_and_Projections_of_Demand_and_Supply
[42] Medicus Healthcare Solutions, *The Anesthesia Provider Shortage*, May 21, 2025, available at: https://medicushcs.com/resources/the-anesthesia-provider-shortage.
[43] Bureau of Labor Statistics, *Occupational Outlook Handbook, Physicians and Surgeons*, 2024 data, available at https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm.
[44] Bureau of Labor Statistics, *Occupational Outlook Handbook, Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners*, 2024 data, available at: https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm.
[45] National Board of Certification & Recertification for Nurse Anesthetists, *Annual NCE and SEE Report: Calendar Year 2025*, available at: https://www.nbcrna.com/docs/default-source/publications-

facilities are relying on CRNAs to fill these gaps. For example, a large population of ambulatory surgical centers are moving to CRNA-only models as it is the most efficient anesthesia care model while maintaining high safety standards.[46] The proposed rule's misclassification of future CRNAs threatens this progress. Access to the professional degree loan amount is a necessary investment in the CRNA workforce and essential health care for patients.

Rural and underserved communities especially rely on CRNAs for surgical, obstetric, and pain management care. CRNAs represent more than 80 percent of the anesthesia providers in rural counties.[47] They are more likely to serve vulnerable patient populations such as those who are uninsured, Medicaid eligible, or unemployed.[48] As more rural facilities close and face closure, investment in the CRNA workforce is critical. CRNA-only models are proven not only safe but the most cost-effective option.[49]

When CRNAs have access to federal loan programs that invest in them, they continue to serve the communities who need care the most. The Nurse Corps Loan Repayment Program is a Title VIII Nursing Workforce Development Program administered by the Health Resources and Services Administration.[50] The Nurse Corps program helps nurses repay their student loans in exchange for at least two years of service in a critical shortage facility or as faculty at a school of nursing. CRNAs who receive support from this program overwhelmingly continue to serve in Health Professional Shortage Areas (HPSAs) which are geographic areas, populations groups, or facilities that have a critical shortage of health professionals providing primary, mental, and dental health. CRNAs support the delivery of all these categories of care from anesthesia for preventive care, such as colonoscopies, to anesthetics used to support dental care for special needs patients and ketamine therapy

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documentation/annual-reports/nbcrna-annual-nce-and-see-report-2025.pdf?sfvrsn=80325e7_2; and National Board of Certification & Recertification for Nurse Anesthetists, *Annual NCE and SEE Report: Calendar Year 2024*, available at: https://www.nbcrna.com/docs/default-source/publications-documentation/annual-reports/2024-annual-report.pdf?sfvrsn=fa53240b_3.

[46] Patsy Newitt, *The Rise in CRNA-only ASCs*, Becker's ASC Review, July 2, 2025, available at: https://www.beckersasc.com/anesthesia/the-rise-in-crna-only-ascs/.

[47] American Association of Nurse Anesthesiology, *CRNAs at a Glance*, available at: https://www.anesthesiafacts.com/wp-content/uploads/2022/11/2022_SGA04_At_a_Glance_FNL.pdf

[48] American Association of Nurse Anesthesiology, *CRNAs at a Glance*, available at: https://www.anesthesiafacts.com/wp-content/uploads/2022/11/2022_SGA04_At_a_Glance_FNL.pdf

[49] American Association of Nurse Anesthesiology, *AANA Statement on Efficiency-driven Anesthesia Modeling*, 2022, available at: https://www.anesthesiafacts.com/wp-content/uploads/2022/03/Efficiency-Driven-Anesthesia-Modeling-white-paper.pdf

[50] Health Resources & Services Administration, *Nurse Corps Loan Repayment Program*, available at: https://bhw.hrsa.gov/funding/apply-loan-repayment/nurse-corps.

for treatment resistant depression.[51] Most recent data show 89 percent of CRNAs who received support from the Nurse Corps program continue to serve in HPSAs.[52]

The Nurse Anesthetist Traineeship Program (NAT) is another Title VIII program and the only federal workforce program dedicated to increasing the number of CRNAs providing evidence-based, high quality, and safe anesthesia and pain management care, especially to patients in underserved and rural areas.[53] For the 2024-2025 school year of the 1,238 participants who received support from the NAT, 989 expanded access to care in a medically underserved community, 244 in a primary care setting, and 476 in a rural area.[54] Graduates from the NAT are surveyed one year after graduation and nearly 56 percent of graduates are currently employed in a medically underserved community.[55] Additionally, 17.5 percent of NAT graduates are serving patients with opioid use or substance use disorders.[56] A growing post-graduation fellowship for CRNAs is nonsurgical pain management. CRNAs are innovative providers leading the implementation of chronic pain management strategies utilizing opioid sparing techniques which are critical for holistic treatment, especially in rural areas.[57]

The Trump Administration has been dedicated throughout its agencies to addressing the crisis of access to care in rural communities. From passing Executive Orders removing barriers to practice that are not evidence-based but bureaucratic, to investing in transforming rural health delivery systems via the Rural Health Transformation Program

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[51] American Association of Nurse Anesthesiology, *Dental Anesthesia*, available at: https://www.aana.com/practice/clinical-practice/clinical-practice-resources/dental-anesthesia/; and American Association of Nurse Anesthesiology, *Ketamine Therapy*, available at: https://www.aana.com/practice/clinical-practice/clinical-practice-resources/ketamine-therapy/.

[52] Health Resources & Services Administration, *Bureau of Health Workforce Alumni Dashboard: Nurse Anesthetist*, Data as of October 1, 2025, available at: https://tableau.hdw.hrsa.gov/t/BHW/views/ClinicianTrackingAlumniDashboards/DetailedRetentionAnalysis?:device=desktop.

[53] Health Resources & Services Administration, *Nurse Anesthetist Traineeship (NAT) Program*, available at: https://www.hrsa.gov/grants/find-funding/HRSA-23-002.

[54] Health Resources & Services Administration, *Health Professions Training Program Dashboard: NAT, 2024-2025 Academic Year, Participant Summary*, available at: https://tableau.hdw.hrsa.gov/t/BHW/views/HealthProfessionsTrainingProgramDashboard/ParticipantSummary?:device=desktop.

[55] Health Resources & Services Administration, *Health Professions Training Program Dashboard: NAT, 2024-2025 Academic Year, Graduate Follow Up*, available at: https://tableau.hdw.hrsa.gov/t/BHW/views/HealthProfessionsTrainingProgramDashboard/GraduateFollow-up?:device=desktop

[56] Health Resources & Services Administration, *Health Professions Training Program Dashboard: NAT, 2024-2025 Academic Year, Graduate Follow Up*, available at: https://tableau.hdw.hrsa.gov/t/BHW/views/HealthProfessionsTrainingProgramDashboard/GraduateFollow-up?:device=desktop

[57] American Association of Nurse Anesthesiology, *A Holistic Approach to Pain Management: Integrated, Multimodal, and Interdisciplinary Treatment Position Statement*, Revised August 2023, available at: https://issuu.com/aanapublishing/docs/1_-_a_holistic_approach_to_pain_management-_integr?fr=sOWM1YTU2NDAxMjU

(RHTP), this Administration champions the role of the advanced practice nursing workforce.[58] These policies include clear calls to action to allow providers to practice to the top of their license and this is especially important for CRNAs as rural communities rely on them the most for live-saving care.

This impact of ED's misclassification of future CRNAs will be dire to the workforce pipeline. AANA surveyed a population of our membership who are potential CRNA program applicants in late 2025 about the student loan caps. The data was clear that the lower cap amount would impact applicants with 75 percent of respondents reporting that CRNA education would no longer be feasible.[59] While many CRNAs fund part of their education with private loans, the heavy reliance required by the lower graduate degree cap will not be possible for many future CRNAs. The lack of protections, often immediate repayment timelines, and high bars to qualify for private loans could leave highly competitive CRNA program applicants forgoing advancing their career. In the AANA survey, 80 percent of respondents were very concerned about securing private loans.[60] Current and future SRNA members have contacted AANA specifically listing how they want to serve their communities by advancing their career, but this cap would force them to give up their aspirations so they can provide for their families. At a time when access to care is reaching a breaking point in rural and underserved areas, ED's misclassification could exacerbate anesthesia workforce shortages by reducing entry into CRNA programs.

VI. Conclusion

We urge ED to include the nurse anesthesia profession (DNP, DNAP) in the definition of professional degree in the final rule, therein complying with statute and avoiding drastic downstream impacts on patient access to care. CRNAs are anesthesia professionals who, due to their specialty, must attend highly rigorous programs that educate and clinically train them to provide the entire spectrum of anesthesia care to all patients, including those with complex medical conditions.

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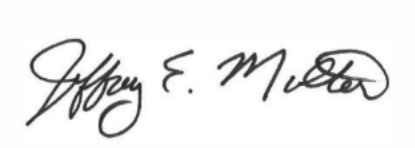
[58] President Trump, *Executive Order on Protecting and Improving Medicare for Our Nation's Seniors*, October 8, 2019, available at: https://www.federalregister.gov/documents/2019/10/08/2019-22073/protecting-and-improving-medicare-for-our-nations-seniors; and Centers for Medicare & Medicaid Services, *Rural Health Transformation Program*, available at: https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview.

[59] American Association of Nurse Anesthesiology, *Impact of proposed federal loan limits on CRNA students: Findings from AANA's Pulse Survey on the affordability of CRNA education*, January 2026, available at: https://www.aana.com/wp-content/uploads/2026/01/Impact-of-Proposed-Federal-Loan-Limits-on-the-CRNA-Workforce-1.pdf.

[60] American Association of Nurse Anesthesiology, *Impact of proposed federal loan limits on CRNA students: Findings from AANA's Pulse Survey on the affordability of CRNA education*, January 2026, available at: https://www.aana.com/wp-content/uploads/2026/01/Impact-of-Proposed-Federal-Loan-Limits-on-the-CRNA-Workforce-1.pdf

We look forward to working with ED to solve these issues and welcome further conversations supporting CRNAs. Please reach out with any questions to Emily Champlin, JD, Associate Director of Regulatory Affairs at echamplin@aana.com.

Sincerely,



Jeffrey E. Molter CRNA, MSN, MBA
AANA President

cc: William Bruce, MBA, CAE, AANA Chief Executive Officer
Romy Gelb-Zimmer, MPP, AANA Director of Regulatory Affairs