Lending to Dental Professionals
How to Make It Painless
[Part One of a Two-Part Series]
Going to the dentist might not be appealing, but lending to one is another story.

BY EDWARD NUNES AND LISA DAVIDSON MCKINNON

The bankers who attend RMA’s course Lending to Medical and Dental Practices tend to hold one of two opinions. The first is that such loans are low risk and require little or no due diligence. Bankers of this opinion are seemingly ready to rush in like patients with no fear of the drill. The other opinion is that dental professionals are poor candidates for loans because they have few tangible assets and too much student loan debt. The bankers thinking this way apparently would need Novocaine just to lend to a dentist, let alone sit in the chair.

The truth is somewhere in the middle, of course, and a financing decision should be based on a strong understanding of the industry (including demand and supply factors) as well as the ability to judge high-quality versus marginal practices (and perhaps just a touch of Novocaine).

Why Are So Many Interested in Lending to Dental Practices?

Despite a contingent of skeptics, the appeal of lending to the dental industry is strong. One reason is the resilience of this roughly $120 billion industry. It held up well during the recent recession, benefiting from favorable demographic trends, technological advances, and an increasing awareness of the link between oral and overall health.

Historically, losses and delinquencies in this industry are relatively low, tending to average about a quarter of the level of all business segments. Charge-off and delinquency rates are low even compared to other medical fields (Table 1), rivaling general medical and veterinary loss rates. It’s said that dental practices typically do not fail for business reasons, but rather because of one of the “Three Ds”—death, divorce, and drugs.

Another appealing factor for lenders: Dental professionals require significant capital. New practices need as much as $500,000 for equipment, leasehold improvements, and working capital. Existing practices will want financing for new equipment, which can include expensive CAD/CAM machines that enable dentists to manufacture crowns in their offices.

Dentists also look to finance leasehold improvements, and in the current low-interest-rate environment they may opt to finance the purchase of their own buildings. The dental industry is one of the most profitable industries in the United States, generating an average operating margin of 17.3%, up from 14% in 2008. Dentists’ relatively high profitability is one reason why they represent a profitable relationship for banks.

Dental Industry: Supply and Demand

By and large, the primary drivers of dental-practice financing requests are practice start-ups and acquisitions.
A number of demographic and other factors can support careful lending.

One is a limited supply of dentists, which suggests a healthy demand—all things being equal—for an individual practitioner’s services. The supply is limited by increased retirements and a drop in the number of new dentists. While the U.S. population grew 9.7% from 2000 to 2010, the number of dentists declined from 166,000 in 2000 to 155,700 in 2010, according to the U.S. Bureau of Labor Statistics. The dental shortage is not found in every corner of the United States, however; it is largely a regional, and in particular rural, issue. The geographic distribution of dentists is closely correlated with the economics of regions as well as the lifestyle preferences of dentists. At present, the largest concentrations of dental practices are found in the Western, Southeastern, Mid-Atlantic, and Great Lakes regions.

The supply is also limited, at least in the near term, by the education requirements for dentists. To practice in the United States, individuals must complete a minimum of eight years of school (four undergraduate and four doctorate) and become licensed in the state where they will work. The U.S. has more than 50 dental schools, which combined graduate an average of 4,100 students per year. The price of education is another barrier to entry. The average dentist finishes school with as much as $250,000 in student debt.

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Demand: Population Growth, Aging, and the Potential for Increased Insurance Coverage

U.S. population growth and the availability of dental insurance are both highly correlated with the demand for dental services. At present, the penetration rate for dental insurance—that is, the number of individuals in the U.S. with dental coverage—is relatively low compared to those with medical insurance. Approximately 49% of Americans have dental insurance; roughly 40% pay out-of-pocket for dental services; 8.5% are covered by Medicaid; and less than 0.5% are covered by Medicare. According to the National Center for Health Statistics, 70% of individuals with dental insurance see their dentist once per year—twice the rate of those without dental insurance.

The Patient Protection and Affordable Care Act requires that state insurance exchanges offer pediatric dental services. In addition, states expanding Medicaid coverage may offer dental insurance to new enrollees. However, it is equally likely that states will cut that benefit in order to manage their budgets under health care reform.

Private dental insurance plans are often expensive, as they require a high level of cost sharing. The maximum payouts for dental insurance are usually about $1,000 to $2,000 a year, according to “Dental Price Clubs: Should You Bite?” by Ben Popken, SmartMoney, June 4, 2012; for procedures such as root canals, individuals have to pay a considerable amount of their own funds. Meanwhile, the “graying of America,” plus the fact that fluoridated water, better tooth brushing, and other factors are helping Americans keep their natural teeth longer, suggest continued demand for dental services as individuals age. Traditional Medicare covers a very limited number of benefits, however.

### Table 2

<table>
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<tr>
<th>Year</th>
<th>General Dentist</th>
<th>Endodontic</th>
<th>Pediatric</th>
<th>Periodontal</th>
<th>Oral Surgeons</th>
<th>Orthodontia</th>
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<td>$869,730</td>
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<td>$1,172,430</td>
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Dental Practice Success Factors: What Makes a Good Borrower

Whether evaluating a loan request to an existing dental practice (for acquisition or other needs) or a start-up, it’s important to consider the following factors.

- **Location:** Both general (positive market demographics) and site-specific (including ease of access and good parking).
- **Payors:** The type of insurance (if any) carried by patients in the practice’s market versus the insurance plans in which the dentist participates.
- **Payment policy:** How the dentist will allow patients to pay their portion of any procedure’s cost (for example, any deductible and co-pay, or the entire cost of the procedure if insurance does not cover it).
- **The strength of the dental team:** This includes the hygienist (as patients tend to spend more time with the hygienist than they do with the dentist).
- **Number of patients:** The growth rate of the patient list and the production (gross billings) per year.
- **Favorable income and expense metrics relative to industry medians:** RMA Statement Studies is a good source of financial data on the dental industry, but for specialties, more nuanced information should be used (Table 2).

More Success Factors:

Questions to Ask Your Prospective Dental Client

Just as any prudent banker would do with a prospective new borrower in any industry, it is important to visit the practice and conduct interviews with the dentist and, if available, the practice manager. Here are some specific questions to ask and observations to make.

**Facility, Environment, and Technology**

Approach the dentist’s office the way a new patient would (but with somewhat less trepidation) and ask yourself these questions:

1. What first impressions would patients have?
2. How many operatories (individual treatment rooms or bays) does the practice have? Is each fully equipped?
3. Does the practice have digital technology and panoramic X-ray and CAD/CAM milling equipment? Is the technology used fully and promoted?

**Patient Scheduling**

How efficiently does the practice schedule its day? Specifically:

1. When is the next opening for a crown appointment or some other significant treatment requiring a block of time?
2. Does the doctor typically keep on schedule? (The answer offers insight into how busy the practice is, whether an associate is needed, and how much may need to be spent on marketing to increase patient count.)
3. Does the practice use a template or formula to tie scheduling to patient volume or production (gross billings) per day?

**New Patient Intake Process**

Does the practice do a good job of retaining new patients and maximizing production per new patient?

1. Does the dental team build relationships, particularly on the phone?
2. How soon is a new patient scheduled?
3. Does the dentist phone new patients prior to their first appointment?
4. Do new patients get a tour of the practice?
5. What type of treatment conference occurs after the clinical examination?
6. Does the practice measure new-case acceptance? (In other words, is it based on just the number of patients seen, or is it relative to the cost of each treatment? Is acceptance much less for larger cases?)
7. Does the practice seek patient referrals and recognize referrals with a thank-you note or small gift?

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**Dental Team Cohesion and Internal Marketing**

The best salespeople are the members of the dental team themselves.

1. Does the team embrace a culture that changes patients’ lives for the better through good health and appearance?
2. Are there protocols for the staff to handle most situations rather than to interrupt the dentist?
3. Does the team meet regularly?
4. Does the practice seem under- or overstaffed? Is the team happy and busy, or busy and stressed? Do they have too much time on their hands?
5. Does the team promote the dentist and case recommendations with conviction?
6. Is there a sales incentive offered to the team members so they become quasi-owners and share profits?

**Insurance**

Knowledge of a practice’s dealings with insurers and patients provides great insights—not only regarding the practice’s ability to collect receivables, but also the dental team’s ability to generate larger case acceptance for treatments not covered by insurance.

1. What types of dental insurance are accepted?
2. What percentage of patients participate in these plans? (A good goal is 50%.)
3. What is the practice’s contractual adjustment percentage (the amount of usual and customary charges not paid by insurance)?
4. How does the practice deal with treatments not covered by insurance?
   - Up-front counseling of the patient?
   - Use of payment plans with a material up-front payment?
5. Does the practice use an electronic claims system?
   - How quick are collections? (The typical is 14 to 30 days.)

**Financial**

How does the practice handle its finances?

1. Does the practice have a budget for key expenses such as clinical supplies or lab?
2. What is the hygiene function’s production as compared to hygiene salaries?
   - Production (gross billings) should be as much as three times larger than salaries.
3. What percentage of revenue is generated by hygiene?
   - 33% is optimal.
   - Hygiene should provide 40% to 60% of the restorative diagnosis in the practice—which means that the hygienist should diagnose 40% to 60% of all cavities, cracked fillings, etc.
4. How are dental associates paid?
   - Industry standard is 35% of production.
5. Does the practice use practice-management software only for billing? Practice software can also track production and collections and provide a template for managing growth expectations.

**Marketing**

How does the practice grow?

1. How many new patients is the practice generating? How are they being generated?
   - Consider how general dental practices market themselves and if those marketing efforts can be tracked.
   - Consider also the relationships with local dental specialists—orthodontists, endodontists, periodontists, and oral surgeons. Are they strong enough to prevent “leakage” of referred patients to other generalists?
   - Understand that specialists typically generate new patients via referrals from generalists. Pediatric dentists tend to receive referrals from pediatricians.

**General Underwriting and Structure Considerations**

**Collateral**

Smaller dental practice transactions can be secured with a first lien on all business assets. Larger transactions may involve more complicated collateral structures.
Dental Practice Business Assets

Unless the dentist owns the real estate, most of the collateral involved is equipment and accounts receivable. But dental equipment is often special-use with a high obsolescence factor. As for dental practice receivables—tread lightly. There are factors to consider when using advance formulas to control line-of-credit availability. For example, many banks will not rely on government receivables as collateral because of anti-assignability issues (Medicare/Medicaid regulations prohibit assignment of receivables to lenders). The good news is that Medicare doesn’t pay for most dental procedures. Medicaid might, but at low margins.

Since 50% or less of an average practice’s revenues are from “third-party payers” (insurance or Medicaid), that means that 50% or more are “patient pay”—that is, paid by the patient either as deductibles, co-pays, or (if no insurance exists) entire bills. The bad news is that patient-pay receivables—whether as part of a dental practice, a medical practice, or a hospital—have a high default rate. Now back to the good news: The dental industry has had years of experience collecting patient-pay receivables. Generally, dentists—particularly specialists, including orthodontists—are good at pre-qualifying a patient’s ability to pay and at collecting up front and/or in installments. Inquire as to the practice’s collections experiences and policies.

Compared to medical practices, dental practices have a higher penetration of electronic medical records systems, including billing. The collection process of insurance payments is also generally faster for dentists (as mentioned above, less than 30 days, on average).

Another tip: Dental real estate should be considered somewhat special-purpose (more so if it is a large and/or surgically oriented practice or if it is located in a medical condominium or if the real estate is zoned for medical/dental). The loan/appraised value should be on the conservative side.

Controls/Covenants

Whereas small business and Small Business Administration loans tend to be “covenant lite” (or “covenant free”), consider the following in cases of large exposures to dental practices:

• Although the dental industry is generally a low-risk segment, a banker can have a problem when the practice is provided large lines of credit that are not monitored or needed for a specific purpose. Most line requests are ultimately for expansion and the dentist will request unrestricted access to the line; however, if usage does not diminish over time, an advance formula can be used to manage line usage, as described above.
• Covenants similar to those used in medical practices include:
  › Pre-distribution debt service coverage.
  › Post-distribution debt service coverage.

› Maximum debt/tangible net worth.
› Limitation on additional indebtedness (including contingent or guaranteed debt).

When setting balance sheet covenants (for example, maximum debt/tangible net worth), it is important to remember that most dental practices are organized as limited liability companies (LLCs) or professional corporations (PCs). As such, they tend to distribute most, if not all, of annual net income to the owners, which results in high leverage.

Personal Guarantees and Other Considerations

In most cases, it is recommended that the dentist-owner provide an unlimited personal guarantee of all indebtedness. As with medical practices, however, pro rata limited guarantees are common with larger practices involving multiple dentist-owners.

Requiring the guarantees to be more than 100% of each dentist’s ownership percentage is smart. The largest dental practices with a high number of dentist-owners (four or more) can be approached on a nonrecourse basis; if so, a savvy banker should employ covenants that would trigger a default if a material number of dentists departed the practice.

Finally, consideration should be given to requiring the assignment of life, disability, and business-interruption insurance, as two of the “3 Ds” mentioned earlier (death and disability) can wreak havoc on a small dental practice.