CGMA MANAGEMENT CASE STUDY FEBRUARY 2019 EXAM ANSWERS

Variant 4

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CIMA will not accept challenges to these answers on the basis of academic judgement.

Section 1

Risks and uncertainties

The most immediate uncertainty is whether patients would be willing to change insurer. They may prefer to remain with National Dental and move to a different insurer instead. Crowncare could evaluate that risk to some extent by asking patients' opinions when they attend for their appointments. There could be a further risk arising from the possibility that National Dental will respond by offering patients a discount if they agree to reverse their request to terminate their existing policies.

This venture will make Crowncare directly responsible for treating patients. At present, if a patient requires an unexpected amount of treatment then Crowncare will carry out the work and can bill National Dental. Crowncare can analyse patterns of treatment using the data in its own clinical records. The number of patients whose care would cost more than their insurance premiums can be estimated. The fact that these risks will be spread across all patients will help enormously. Crowncare will benefit from those patients who require less work than expected.

There could be a risk that Crowncare's dentists will change their treatment plans if they are no longer accountable to an external insurance company. They could start offering treatment that might otherwise have been withheld in the case of minor issues or complete restorative work to a higher standard. That risk will be difficult to evaluate, but the Board will have to ensure that all dentists are properly briefed about the reasons for the change and agree not to carry out unnecessary work.

There is an upside risk that Crowncare's overall profitability will increase because it will no longer be passing the profit over to National Dental. The upside risk may be limited by the need to manage and administer the scheme,

which makes patient numbers a significant issue. The running costs are likely to be fixed and so patient numbers will determine the extent to which the plan makes a profit.

Competitive advantage

Crowncare proposes to compete with two groups of rivals: other dentists and other insurers.

In competing with dentists, Crowncare's selling proposition is that any dental treatment that is required can be assessed purely in terms of clinical need. Patients may find it reassuring that Crowncare is not required to seek clearance before offering more expensive procedures. Patients will also be reassured that Crowncare will not have any incentive to carry out unnecessary dental work, which would then be paid for by a third-party insurer.

If Crowncare's own captive insurance company does give it an advantage over other dentists then the advantage should be sustainable because Crowncare is a large dentist with a significant body of patients. Smaller dental practices would find it more difficult to create this advantage for themselves, unless they did so through a joint venture or some other form of collaboration that would be more complicated to establish and maintain than Crowncare Plan. If such a direct competitor is established then Crowncare should be able to adapt its product in response because it has total control.

Other insurers will find it difficult to entice patients to insure with them because Crowncare has a direct and personal relationship with these customers as individuals. If Crowncare refuses to work with any other insurance company then patients will be forced to find a new dentist if they wish to change insurers. If Crowncare has taken good care of its patients then they may be unwilling to change to an alternative.

Insurers will struggle to undercut Crowncare on price because they will have to pay full dental fees to another dentist in order to discharge their responsibilities to patients. Crowncare effectively obtains the dental treatment at cost and so it can afford to match competitors' prices. Crowncare also has the ability to communicate directly with its patients, while a competitor would not have contact details and so would have to market itself in a less efficient way.

Section 2

Budget reports

The report is intended to provide feedback on the commercial performance of the practices and that focus should continue.

The first issue that has to be addressed is whether to report the revenue from patient premiums. Arguably, it would be unhelpful to credit practices with that revenue because it is not directly under their control on a month by month basis. Practices should be informed of the numbers of patients joining and leaving the practice on a month by month basis because attracting and retaining patients is the key to Crowncare's long-term success. Practices should also be informed of the numbers of patients who sign up for Crowncare Plan, at least during the transitional period, because practice staff will be in a position to encourage patients to take the insurance.

It is no longer particularly helpful to break revenues down between insured and uninsured. Dentists should not be given any reason to distinguish between patients on the basis of the manner that they pay for their care, otherwise they may perceive some pressure to withhold treatment from patients whose care is essentially being paid for by Crowncare itself. It may seem counter-intuitive to show fee income from patients who are covered by insurance, but providing patients with dental services is the basis of Crowncare's business model.

The revenues should be broken down and subtotaled more clearly to show income from the three categories of preventive, restorative and cosmetic dentistry because these are important decisions from a commercial point of view. Preventive care is a key commercial activity, partly because all patients require regular dental checks and dental hygiene and so it reflects patient numbers who actively use the practice. Cosmetic treatment is discretionary and so practices should be encouraged to promote it as vigorously as possible. Laboratory work should also be broken down between restorative and cosmetic, partly to add further distinction between restoring damaged teeth and improving patients' appearance. The distinction will also give a quick insight into the overall scale of the work being done under each category, alongside the associated value added in the surgery. It could, in any case, be argued that the sale of laboratory work is part of the practice's revenue, even if it was sold at cost.

Financial reporting

Even though this policy is described as "dental insurance", it is debateable whether it is really, or at least entirely, insurance in the conventional sense of paying a premium in order to transfer risk. Patients pay a monthly fee, in return for which they receive preventive care in the form of examinations and hygienist appointments that they would otherwise have to pay for in order to maintain their dental health, so there is no real transfer of risk. The premiums

effectively act as prepayments, at least in part, for this preventive treatment and so there is a question of the recognition of revenue.

The revenue from the prepayments for preventive care should be accounted for in accordance with IFRS 15 *Revenue from Contracts with Customers.* The revenue for the examinations and hygiene appointments should be recognised as and when the treatments are provided. The cash received from patients will, therefore, be credited to accruals as and when it is received.

There is a conventional insurance element in the sense that the policy covers any restorative dental work that they require while their policies are active. The policies appear to run from month to month and they can be cancelled at will, in which case the cover will also lapse. That raises the question of the liability that ought to be recognised with regard to this policy.

The insurance element of the payments will be recognised as revenue when the cover is earned. It appears that each monthly payment pays for a month's cover in advance. That means that the premiums are prepayments when they are received, but they are transferred to revenue at the month end. Crowncare will also have to recognise the liabilities arising in respect of this cover as at the year-end. Given the short term nature of the policy, Crowncare will be able to limit the liabilities that it recognises to the cost of providing treatment under agreed treatment plans that have been established during the year, plus an element to cover claims that could arise from the insurance provided during the final month of the financial year.

Candidates could have referred to IFRS 4 Insurance Contracts *in their discussion, and would have been awarded credit for doing so where relevant. They were not required to do so in order to earn full marks.*

Section 3

Pricing strategy

Crowncare's pricing strategy should reflect the fact that it is seeking an ongoing commitment from its customers for monthly payments. These costs will be even more significant when considering household budgets because the fees will be multiplied by the number of adults in the household taking the insurance. Most patients will not receive much in return for these payments, other than their check-ups and quarterly hygiene visits, which means that they will see no immediate benefit from their regular payments unless they require restorative treatment. If the insurance cover is deemed too expensive then patients may decide to pay for treatment as they go, in which case they may not have the same incentive to pay for preventive care and they may not necessarily use their Crowncare practice if they suffer from toothache.

Crowncare's starting point in setting a strategy is that the vast majority of its patients have been willing to buy dental insurance from third party insurers and so their policy prices offer a starting point for pricing decisions. It would be sensible to offer patients a small discount to the prices that they paid previously, in the spirit of penetration pricing. Patients will be motivated to sign up if Crowncare offers them a decrease in premium and Crowncare can afford to do that because it is also making a profit from the dental treatments. Once the scheme is established, it will be possible for premiums to creep back to previous levels because it will be difficult to compare the cost of alternative cover without seeking a quotation and that would involve a change of dentist.

Crowncare could also offer an element of product bundling in order to make this scheme appear more attractive. One approach would be to add value to the policy by discounting other elements of the dental care, such as cosmetic treatment or dental implants. The discounts may seem attractive to patients, although they may not actually be able to take advantage of them and so in many cases the cost to Crowncare will be zero. The discounts would also be granted on high value and high margin treatments that Crowncare will always be keen to sell and a small discount on such treatment may actually generate more profit through greater volume.

Published financial statements/Practice Managers

The basic problem is that the financial statements show the revenues and costs in the aggregate. We cannot tell how much a competing dentist makes from, say, cosmetic work. We may be able to establish fees independently by looking online for price lists or by seeking a telephone quotation, but that says little about the ability to compete because the financial statements will not enable us to determine costs. Even taking a basic ratio such as the gross profit percentage will tell us very little about fixed versus variable costs and contributions and so it will be difficult to tell whether there could be scope for a competitor to reduce prices.

There is a further confounding factor in that many dentists operate in sectors in which we have no interest in competing and so any information taken from their financial statements could be misleading. For example, Crowncare is exclusively a private practice. Many competing dentists are prepared to accept patients under the VHS scheme. Apart from confusing any comparison against Crowncare, the VHS work will provide some competitors with a strong base that can be used to generate profits that could enable a reduction in prices for private care.

Having the Practice Managers review treatment plans could lead to the dentists feeling undermined by the management structure. The Practice Managers are not qualified to make clinical decisions and so any discussion will focus on justifying incurring a cost. The scheme will only succeed in reducing overall costs if the reviews sometimes lead to a treatment being cancelled or replaced. That could affect dentists' relationships with their patients and could lead to a loss of confidence.

Having individual Practice Managers review treatments could lead to inconsistencies in the standard of care offered by different practices. Some Practice Managers may be more skeptical than others and so the ability of some practices to offer important treatments could be affected. It would make more sense to compare practices and even dentists within practices to establish whether any appear to be prescribing more expensive treatments. It may be more appropriate for any differences to be discussed with the appropriate Head of Practice, who will be a qualified dentist and can talk through the clinical arguments in an informed way.

Section 4

Change management

The first thing that we need to do is be clear about the nature and extent of any change. For the moment, the only change that has actually been made is a report on the cost of planned treatments, with no explicit suggestion that the approach to treatment should change. The dentists are trained professionals and they may resent any change that appears to undermine their authority. It should be made clear that Crowncare is a profit-making company that sells private dental care and that it is important to keep costs under review, if only to protect jobs.

If dentists have a clearer understanding of the need for change then they may be less hostile to the changes that are being introduced. Crowncare should make it clear to dentists that the insurance company that provided cover before the creation of Crowncare Plan was almost certainly providing a reality check to ensure that treatment plans were realistic. Even if the dentists did not consciously consider the insurance company, they would have been aware of its interest in their clinical decisions and the associated need not to carry out unjustified work.

The change process could be presented as a dialogue concerning the norms that should be established. There could be a discussion as to when certain treatments are justified and when another approach should be taken. A formal change management process would encourage such a dialogue and would, therefore, have the effect of making it appear less threatening.

Once the changes have been agreed Crowncare should take care to ensure that the dentist are given feedback on the success of the changes and, ideally, given some more tangible encouragement. If jobs are more secure because costs are being kept under control then that should be communicated. It may be sufficient to circulate some statistics about the extent to which the more expensive procedures are being carried out, partly to reflect that they can still be used when appropriate and partly to demonstrate, hopefully, that their use can be curtailed with no ill effects.

Costing system/issuing shares

The diagram presented by Frank does not necessarily support the need for a more complicated costing system. The vast majority of patients require little or no restorative treatment and so they yield profits. The whole point of an insurance scheme is that the insurer will accept a risk from the insured and that there will be a small number of cases where the costs exceed the revenues from premiums.

Frank's chart demonstrates that it is possible to make a rough estimate of the cost of different treatments. He was sufficiently confident to circulate the results to Crowncare's Board. On that basis, a better costing system would simply lead to a significantly increased cost, with no great benefit if the estimates are sufficiently accurate for discussion purposes.

An ongoing concern is that Crowncare must provide patients with the restorative treatment that they require, regardless of the cost. If a patient has tooth decay or has broken a tooth then the damage must be repaired, whether that is in Crowncare's financial interests or not. If Crowncare is making a profit overall then it makes very little difference if some treatments are effectively loss-leaders that are the cost of attracting patients and retaining their custom.

Granting a dentist a small number of shares could create a sense of identification with the company and might encourage them to pay more attention to saving money. There could be other ways to create a sense of identity though, such as social events that could be more successful.

Issuing significant numbers of shares will dilute the ownership interests of the existing body of shareholders. There are only 40 of them and so the issue may reduce their interest significant. The dilution could be justified if the dentists were sufficiently motivated to make profits that overall performance increased drastically, but that seems unlikely.

As professional people, the dentists are not necessarily motivated entirely by economic benefits. They are already well paid and may not be concerned about a further increase in their income. They may also be motivated by a desire to treat their patients to the best of their ability, even if doing so would lead to a financial cost.