RATE MANUAL
EFFECTIVE JANUARY 1, 2005
LOUISIANA PATIENT'S COMPENSATION FUND

I. PCF PAYMENT SCHEDULE

New Enrollees:

Providers With Primary Insurance: Payment must be made on or before the effective date of coverage. If payment is made after the effective date of the primary policy, the PCF effective **date** will be the date the insurance company/agent **received** the payment on behalf of the PCF. Proof of provider's payment may be requested.

Self Isured's : The effective date of coverage is the **date of receipt** by the PCF of the completed application, the appropriate surcharge payment and the security in the amount of $125,000.00.

Renewals:

Providers With Primary Insurance: Payment must be made to the insurance company or agent NO LATER than **30** days after the expiration of the policy.

Self Insured's: The effective date of coverage is the date the PCF has **received** the completed application, appropriate surcharge payment and renewal information for the security. Payments need to be sent on or before he date of renewal.

Tail Coverage: Must be purchased from primary within **45** days of termination of policy.

*******LATE PAYMENT BY THE HEALTHCARE PROVIDER WILL RESULT IN A GAP IN COVERAGE.*******

RESPONSIBILITY OF THE INSURANCE COMPANY/AGENT

Once payment is received by the insurance company/agent, the following is remitted to the PCF:

1. A certificate of insurance that includes the complete name and address of the HCP, specialty, license number, date of birth, dates of coverage, policy type, retro date (if applicable) and primary premium.
2. Appropriate surcharge payment. If other than what is found on the PCF rate sheet, an explanation is needed as to how it was calculated, such as part-time.

The insurance company/agent has **45** days from the date they receive the payment from a HCP to remit it to the PCF. If remitted past the 45 day period, a **12% penalty** will be charged to the insurance company/agent if the payment was due prior to 1/1/05. Payments due after 1/1/05 will be charged **5% + accured legal interest** from the 46th day

until paid. Proof of the primary payment will be requested if a payment is remitted beyond time allowed.

Notices of **cancellations** must be received within 30 days of effective date for full refund back to date of cancellation. Refunds will be made for current policy only.

II. CLASSIFICATION PROCEDURE:

A. For classification assignment purposes, the following phraseology is defined:

1. The term "**no surgery**" applies to general practitioners and specialists who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia) and who do not ordinarily assist in surgical procedures.

2. The term "**minor surgery**" applies to general practitioners and specialists who perform minor surgery.

3. The term "**major surgery**" applies to general practitioners and specialists who perform major surgery or who assist in major surgery on their own or on other than their own patients. Tonsillectomies, adenoidectomies, abortions, dilation and curettement, laparoscopic procedures, normal obstetrical procedures and cesarean sections shall be considered major surgery.

B. When two or more class are applicable to a general practitioner or specialist, the rate for the **highest** paid class shall apply.

C. Any general practitioner or specialist who would normally be assigned to a class having a code number followed by an asterisk (*) shall be classified and rated as "**Physicians--no major surgery**", code 80534, if any of the following medical techniques or procedures are preformed:

a. **Acupuncture**--other than acupuncture anesthesia
b. **Cryosurgery** -- other than use on benign or pre-malignant dermatological lesions
c. **Lasers** -- used in therapy
d. **Shock therapy**
e. **Liposuction**
f. **Skin flaps with arterial blood supply** other than cancer therapy
g. **Any dermatological procedure done under general anesthesia**
h. **Epidural injections** – for pain management

D. Any general practitioner or specialist who would normally be assigned to a classification having a code number followed by a cross-hatch (#) shall be classified and rated as "**Physicians -no**

major surgery", code 80533, if such general practitioner or specialist performs any of the following medical techniques or procedures:

a. **Catheterization** -- arterial, cardiac, central venous, or diagnostic, intraluminal angioplasty, occasional insertion of pulmonary wedge, recording catheters or temporary pacemakers, and umbilical cord catheterization for diagnostic purposes or for monitoring blood gases in newborns receiving oxygen.
b. **Needle biopsy** -- including lung, liver, kidney, and prostate.
c. **Radiopaque Dye Injections** into blood vessels, lymphatics, sinus tracts or fistulae (not applicable to Radiologist, Code 80280*)
d. **Pneumatic and mechanical esophageal dilation** (not with bougie or olive)

E. **Nursing Home** applies only to a **licensed** "home" as defined in R.S. 40:2009.2. A nursing home may include both skilled nursing beds as well as other beds, in which case the number of each type of bed must be included on the application and the appropriate surcharge remitted. A skilled nursing facility bed includes beds licensed or approved as such by the State and utilized for patients requiring either skilled nursing care or the supervision of skilled nursing care on a continuous and extended basis and corresponds to Medicare Part A skilled. Intermediate care corresponds to Medicaid Skilled. The PCF Other class corresponds with Medicaid Intermediate.

F. **Locum Tenens Coverage:** The PCF requires a surcharge for Locum Tenens. The surcharge is prorated based on the class and specialty of the physician who is utilizing the Locum Tenen and the number of days worked. The PCF provides for a minimum of $250.00 or whichever is higher. When a physician completes the indicated period of time listed on the certificate of insurance, and he elects to return at a later point, he will be required to pay an additional surcharge based on the number of days worked.

G. **Orthopedic Minor Surgery** includes outpatient procedures such as toe surgery, arthroscopic procedures, closed reductions, percutaneous pinning and other percutaneous procedures.

H. **Corporate Coverage:** For Corporate coverage, a certificate of insurance is **required**. It must contain the names of the providers eligible for enrollment (HCP specialities listed in our rate manual) that make up the Corporation or Partnership, or work for the corporation or partnership, so that coverage can be verified and to confirm that no additional surcharge is due. No certificate of enrollment will be issued if there is a failure to comply with this provision and coverage will not be established within this office.

III. PHYSICIANS AND SURGEONS CLASSIFICATIONS

	Code Number	Class
Administrative Medicine.....	80025	1A
Aerospace Medicine	80230*#	1A
Allergy	80254*#	1A
Anesthesiology	80151	3
(This classification applies to all general practitioners or specialists who perform general anesthesia or acupuncture anesthesia)		
Bariatric Medicine	80229	1
Broncho-Esophagology	80101	3
Cardiovascular Disease - major invasive	80109	3
(This classification applies to any cardiologist performing any of the following procedures:Angiography, Intraluminal angioplasty, Myelography)		
Cardiovascular Disease -minor surgery	80281*	3
Cardiovascular Disease - no surgery	80255*#	2A
Dermatology - minor surgery	80282*	1A
Dermatology - no surgery	80256*#	1A
Diabetes - minor surgery	80271*	2
Diabetes - no surgery	80237*#	1
Emergency Medicine- including major surgery	80157	5
(This classification applies to any general practitioner or specialist regularly engaged in emergency practice at a clinic, hospital or rescue facility who performs major surgery) ****SEE NOTES FOR OPTIONAL PER PATIENT VISIT RATING BASIS***		
Emergency Medicine - no major surgery	80102	4
(This classification applies to any general practitioner or specialist regularly engaged in emergency practice at a clinic, hospital or rescue facility who does not perform major surgery ****SEE NOTES FOR OPTIONAL PER PATIENT VISIT RATING BASIS***		
Endocrinology - no surgery	80238*#	1
Family Practice - minor surgery	80273*	2
Family Practice - no surgery	80239*#	2A
Family Practice, not primarily engaged in major surgery but including routine obstetrical procedures, no C-sections nor laparoscopic procedures	80117	3
Family Practice - primarily engaged in major surgery	80142	5
Forensic Medicine	80240*#	1A
Gastroenterology - minor surgery	80274*	2
Gastroenterology - no surgery	80241*#	1
Gastroenterology -major invasive procedures	80535	3

(This classification applies to any gastroenterologist performing colonoscopies, endoscopic retrograde cholangiopancreatographies and/or peritoneoscopies)

	Code Number	Class
General Practice - minor surgery	80275*	2
General Practice - no surgery	80242*#	1
General Preventative Medicine - no surgery	80231*#	1A
Geriatrics - minor surgery	80276*#	2
Geriatrics - no surgery	80243*#	1A
Gynecology - minor surgery	80277*	2
Gynecology - no surgery	80244*#	1A
Hematology - minor surgery	80278*	2
Hematology - no surgery	80245*#	1
Hypnosis	80232	1
Infectious Disease - minor surgery	80279*	2
Infectious Disease - no surgery	80246*#	2A
Intensive Care Medicine	80339	3
(This classification applies to any general practitioner or specialist employed in an intensive care hospital unit)		
Internal Medicine- minor surgery	80284*	2
Internal Medicine - no surgery	80257*#	2A
Laryngology - minor surgery	80285*	2
Laryngology - no surgery	80258*#	1
Neonatology - intensive care medicine	80283	2
Neoplastic Dis./Oncology - minor surgery	80286*	2
Neoplastic Dis./Oncology - no surgery	80259*#	1
Nephrology - minor surgery	80287*	2
Nephrology - no surgery	80260*#	1
Neurology -including child-minor surgery	80288*	2
Neurology-including child-no surgery	80261*#	2A
Nuclear Medicine	80262*#	1
Nutrition	80248*#	1
Occupational Medicine	80233*#	1A
Orthopedic – no surgery/procedures.....	80401	1
Orthopedic – Minor surgry/procedures.....	80402	3
Ophthamology - minor surgery	80289*	2
Ophthamology - no surgery	80263*#	1A
Otology - minor surgery	80290*#	2
Otology - no surgery	80264*#	1
Otorhinolaryngology - minor surgery	80291*	2
Otorhinolaryngology - no surgery	80265*#	1A
Pain Management – Specialist.....	80325	3
Pathology - minor surgery	80292*	2
(Coverage is included for pathological laboratories)		

	Code Number	Class
Pathology - no surgery	80266*#	1
(Coverage is included for pathological laboratories)		
Pediatrics - minor surgery	80293*	2
Pediatrics - no surgery	80267*#	1
Pharmacology - clinical	80234*#	1A
Physiatry ..(no Surgery/ no pain management).....	80235*#	1A
Physicians - minor surgery	80294*	2
(This is an N.O.C. classification)		
Physicians - no major surgery	80534	3
(This classification applies to all general practitioners or specialists except those performing major surgery, anesthesiology or acupuncture anesthesiology, who perform any of the following procedures:		
Acupuncture - other than acupuncture anesthesia		
Cryosurgery - other than use on benign or pre-malignant dermatological lesions		
Lasers - used in therapy		
Shock therapy		
Skin flaps with arterial blood supply other than cancer therapy		
Liposuction and/or any dermatological procedure done under general anesthesia		
Epidural injections - for pain management		
Physicians - no major surgery	80533	2
(This classification applies to all general practitioners or specialists except those performing major surgery, anesthesiology or acupuncture anesthesiology, who perform any of the following medical techniques or procedures:		
Catheterization - arterial, cardiac, central venous, or diagnostic, occasional insertion of pulmonary wedge, recording catheters or temporary pacemakers, and umbilical cord catheterization for diagnostic purposes or for monitoring blood gases in newborns receiving oxygen.		
Needle Biopsy including lung, liver, kidney and prostate		
Radiopaque Dye Injections into blood vessels, lymphatics, sinus tracts and fistulae		
(**NOT APPLICABLE TO RADIOLOGISTS, CODE 80280***)		
Physicians- N.O.C. (No procedures)	80236	1A
Physicians - no surgery	80268*	1
(This is an N.O.C. classification)		
Podiatry.....	80003	2
Psychiatry - including children	80249*#	1A
Psychoanalysis	80250#	1

	Code Number	Class
Psychosomatic Medicine	80251*#	1
Pulmonary Disease - no surgery	80269*#	2A
Radiology -diagnostic - minor surgery ..... (Including radiopaque dye injections into blood vessels, lymphatics, sinus tracts or fistulae. Coverage is included for X-Ray Laboratories)	80280*#	2
Radiology-diagnostic - no surgery ..... (Coverage is included for X-Ray Laboratories)	80253*#	2A
Radiology -major invasive procedures ..... (This classification applies to any radiologist performing angiographies, arteriographies, discograms, lymphangiographies, myelographies, phlebographies, pnuemoencephalographies, and/or radiation therapy)	80536	3
Rheumotology - no surgery	80252*#	1
Rhinology - minor surgery	80270*	2
Rhinology - no surgery	80247*#	1
Surgery - abdominal	80166	5
Surgery - cardiac	80141	7
Surgery - cardiovascular disease	80150	8A
Surgery - colon and rectal	80115	3
Surgery - endocrinology	80103	5
Surgery - gastroenterology	80104	5
Surgery - general ..... (This is an N.O.C. classification. This classification does apply to any general practitioner or specialist who occasionally performs major surgery)	80143	6
Surgery - general practitioner or family practitioner, not primarily engaged in major surgery but including routine obstetrical procedures, no C-sections nor laparoscopic procedures	80117	3
Surgery – general practitioner or family practitioner, engaging in major surgery (NOT GENERAL SURGEON)....	80142	5
Surgery - geriatrics	80105	5
Surgery - gynecology	80167	5
Surgery - hand	80169	3
Surgery - head and neck	80170	7
Surgery - laryngology	80106	5
Surgery - neoplastic	80107	5
Surgery - nephrology	80108	5
Surgery - neurology- including children	80152	8
Surgery - obstetrics	80168	7
Surgery - obstetrics/gynecology	80153	7
Surgery - ophthamology	80114	2
Surgery - orthopedic	80154	6

	Code Number	Class
Surgery - orthopedic -spinal surgery	80172	8
("Spinal surgery" includes any open procedure on the spine, except myelograms, epidural steroid injections, and diagnostic procedures)		
Surgery - otology	80158	5
(This classification does not apply to general practitioners or specialists performing plastic surgery)		
Surgery - otorhinolaryngology	80159	4
(This classification does not apply to general practitioners or specialists performing plastic surgery)		
Surgery - plastic	80156	5
(This is an N.O.C. classification)		
Surgery - plastic- otorhinolaryngology	80155	5
Surgery - rhinology	80160	5
Surgery - thoracic	80144	6
Surgery - traumatic	80171	6
Surgery - urological	80145	3
Surgery - vascular	80146	6

III. SUPPLEMENTAL NOTES AND CHARGES

A. The following additional charges shall apply for ALL indicated classifications, including such practitioners employed by others(2)(3)(4):

Corporate Liability		80999	20% of each individual class rate (1)
Partnership Liability		80999	20% of each individual class rate (1)
Advanced Practice RNs: Licensed Physicians' Assts., Surgeons' Assistants, Nurse Pract. and Nurse-Midwives		80129	Class 1 rates, or 75% of rate applicable to supervising physician, whichever is lower.
Locum Tenens Physician Liab.		80177	100% of stated surcharge prorated for period worked (Minimum $250)
Chiropractors	(ALL OTHER)		87% of primary ($250 Min.)
Optometrists	(ALL OTHER)		87% of primary ($250 Min.)
Psychologists	(ALL OTHER)		87% of primary ($250 Min.)
Pharmacists	(ALL OTHER)		87% of primary ($250 Min.)

Shock Therapy- by insured surgeon or physician involved with major surgery

80162 75% of class 1 surcharge

(This additional charge applies to each surgeon or physician doing shock therapy work)

Radiation Therapy-by insured surgeon or physician involved with major surgery

80165 75% of class 1 surcharge

Nurse Anesthetist- 80900 See Rate Manuel for CRNA

NOTES:

(1) No charge will be made to cover such entity if all shareholders/ partners and professional employees are qualified with the PCF. Otherwise a charge of 20% of each class rate will be made for shareholders/partners and employees not qualified in the PCF. A separate Certificate of Insurance is required that lists all enrolled health care providers in the Corporation/Partership.

(2) These rates apply not only to employees of individual providers, but also to employees or partnerships, corporations or professional associations practicing medicine. They apply per employee regardless of the number of partners.

(3) Any of the above special surcharge classes must be paid in addition to surcharges applicable for employing provider.

(4) The **$250 minimum** charge is a POLICY-WRITING MINIMUM for the LAPCF, and may not be pro-rated.

B. A physician or surgeon reducing classification will pay a one-time additional surcharge equal to the difference between the "tail" (reporting endorsement) charge for the higher classification and the tail charge for the lower classification. It will be based on the provider's maturity year at the time of the change.

C. A physician or surgeon who is employed full-time by a hospital or clinic and has paid a full surcharge for his classification. and who is in addition in private practice may be eligible for a rate credit on the surcharge for his private practice, as follows:

35 hrs. practice/month or less .....75% credit
65 hrs. practice/month or less .....50% credit
85 hrs. practice/month or less .....25% credit
More than 85 hrs./month .....…..... No credit

At the discretion of the Fund, these percentage credits may also be applied to physicians practicing on a part-time basis.

D. A physician or surgeon with a rate class in their primary insurance company that is different from the rate class shown in these pages for the Patients' Compensation Fund will in all instances pay the surcharge based on the PCF rate classes.

E. **Intern and Resident Rating Procedures:**

General Medicine .....Rate Class 3
General Surgery .....….Rate Class 5
Transitional (Med./Surg.) ….....Rate Class 4
Pediatrics .....….Rate Class 1
Psychiatry .....….Rate Class 1
Other .....…...PCF Rate class applicable to specialty

Interns: 33% of indicated surcharge for applicable class

Residents: 66% of indicated surcharge for applicable class

F. **Retiring, Deceased or Disabled Physicians**: "Tail" coverage (Reporting Endorsement) premiums for these classes shall be considered as "included" in their last surcharge payment, and no additional charge shall be required for this coverage if they have been in the PCF for 10 consecutive years. However, a disabled physician who subsequently returns to practice must pay all applicable surcharges, just as any other active physician. This deferral also applies to the "step down" charge used for physicians who reduce their PCF classification. If such reduction the result of a permanent disability or illness which allows the provider to continue to practice medicine, but requires a reduction in the specialty class (for example, dropping to a "no surgery" classification after previously qualifying as a surgeon or surgical assistant), the "step down" charge shall be considered "included" in the last surcharge paid at the higher classification.

G. Classes which do not fall within the range of these pages shall be rated at the discretion of the Fund. In most cases, such rates will follow the Insurance Service Office procedures.

H. ALTERNATE EMERGENCY PHYSICIAN RATING BASIS:

This rating basis is an option available to any group or individual Emergency Medicine practice whose underlying coverage is rated on a "per patient visit" basis (or, for self-insureds, those whose hospital contracts are maintained on a "per patient visit" basis). To qualify for this basis, providers must be able to supply the Fund with the means of verifying the number of patient visits recorded at year end. Such verification can take the form of premium audits from underlying policies, copies of verifications for hospital contracts, or any other form of verification acceptable to the Fund. Surcharges paid to the Fund will be adjusted at the end of each policy year based on verified numbers submitted. (PLEASE NOTE: This rating basis is the only alternative available to rating Emergency Medicine on a per-physician basis. Under no circumstances will any ER group or practice be rated as per the "All Other" rating procedures.)

Rates per patient visit are as follows. At the discretion of the Fund, where it is not possible to sort patient visits per physicians' individual retro-active dates, an average Claims-Made rate may be available as shown. Use of the average rate requires a written request to the Fund. Use of an overall retroactive date per group will not be allowed.

CLASS	**CLAIMS-MADE MATURITY YEAR**					**OCCURRENCE**
Regular Coverage:	1	2	3	4	5	
4	1.11	1.84	2.20	2.33	2.49	2.71
5	1.13	1.88	2.22	2.42	2.52	2.72
"Tail" Coverage:						
4	1.98	2.83	3.16	3.28	3.28	
5	2.04	2.91	3.20	3.35	3.35	

Average Claims-Made Rates: (*****These rates are only to be used by providers that are already using them. New Providers cannot use these rates.**)***

	Regular Cov.	"Tail" Cov.
Class 4-	1.99	2.90
Class 5-	2.06	2.96

LA PATIENT'S COMPENSATION FUND RATE PAGES

SUPPLEMENT : EXPERIENCE RATING

1. General:

Effective 7-1-93, the LA PCF initiated an experience-rating program for physician and hospital classes. The intent of the plan is to apportion a greater percentage of needed premium increases to those providers who are generated a greater-than-expected number of losses. This program replaces the 10% loss-free credit program previously available. That credit is currently not available.

While the provisions for application to the physician and hospital classes are slightly different, both operate under the following general parameters:

A. Only those providers with two or more eligible losses in the five-year rating period, valued at $2 or more each, will be affected. Not every provider meeting the criteria for rating shall earn a debit: a number of providers whose total losses fall below the indicated thresholds will simply pay manual premiums, like any other provider.

B. Losses subject to inclusion are as follows:

1. Any closed, paid loss (valued at $2 or more) with a report date of 5 years prior to the renewal date; AND

2. Any open, reserved loss valued at $2 or more, regardless of original report date.

3. The "All Other" class will be experience rated under PH1 unless the providers included are classified at a higher level.

C. Losses used in the rating plan will be valued as of 90 days prior to the expiration of the provider's coverage. Any changes in loss value after that date will be included in the next year's evaluation.

D. Because the majority of the required information is only readily available to the Fund (rather than the providers and primary carriers), Fund personnel will calculate all modifiers in our offices, and send appropriate notice to the providers and carriers in our renewal billings. However, each affected provider will be given a copy of the worksheet used in the calculation, so that they may review the loss data for accuracy.

E. Penalties are required in addition to the indicated surcharge increase shown in the attached rating pages.

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2. Physician Class Program Specifics:

A. The physician-class modifiers rely on specific ranges of losses. These vary by PH-class. Those eligible providers with total limited losses in the five-year period which fall within the stated ranges shown below will earn the indicated debit modifier.

B. Modifiers are to be applied to the indicated renewal surcharge. (For example, a provider paying $10,000 in normal surcharges who earns a 20% penalty will pay a total of $12,000-- i.e., $10,000 X 1.20).

C. The indicated modifier shall be re-evaluated at each subsequent renewal. It is anticipated that providers will come in and out of the program as loss results change.

D. The maximum penalty to any provider is 50%.

E. Indicated modifiers and loss limitations by class:

PH-1A, 1 & Others	
%Debit	Loss Range
0	up to $15,866
10	$15,867 to $47,049
20	$47,050 to $92,849
30	$92,850 to $153,010
40	$153,011 to $222,785
50	$222,786 or more

PH-2A & 2	
%Debit	Loss Range
0	up to $26,184
10	$26,185 to $60,301
20	$60,302 to $118,115
30	$118,116 to $185,168
40	$185,169 to $273,491
50	$273,492 or more

PH-3	
%Debit	Loss Range
0	up to $38,897
10	$38,898 to $83,993
20	$83,994 to 148,956
30	$148,957 to 124,299
40	$224,300 to 335,628
50	$335,629 or more

PH-4	
0	up to $47,598
10	$47,599 to $88,159
20	$88,160 to $156,893
30	$156,894 to $236,611
40	$236,612 to $341,618
50	$341,619 or more

PH-5	
0	up to $57,284
10	$57,285 to $108,547
20	$108,548 to $182,394
30	$182,395 to $279,669
40	$279,670 to $394,599
50	$394,600 or more

PH-6	
0	up to $71,227
10	$71,228 to $118,825
20	$118,826 to 199,484
30	$199,485 to 293,033
40	$293,034 to 416,258
50	$416,259 or more

PH-7	
0	up to $109,452
10	$109,453 to $178,112
20	$178,113 to $277,021
30	$277,022 to $423,171
40	$423,172 to $599,077
50	$599,078 or more

PH-8A & 8	
0	up to $131,664
10	$131,665 to $209,925
20	$209,926 to $307,642
30	$307,643 to $435,997
40	$435,998 to $605,070
50	$605,071 or more

3. Hospital Program Specifics

A. Hospital modifiers are individually calculated based upon the provider's 5-year loss ratio with the Fund: that is, the relationship of surcharges paid in to losses paid out and reserved within the same five-year period. The losses shall be subject to the limitations shown below. The indicated modifier shall be the debit (if any) indicated by the loss ratio (i.e., any portion over 100%), subject to the maximum penalty of 50%.

B. MAXIMUM SINGLE LOSS PROVISIONS: Those hospitals who have paid a cumulative total of less than $300,000 into the Fund in the past five policy years shall have each individual loss limited to $300,000 for experience rating. Those hospitals which have paid in a cumulative total of $300,000 or more over the past five policy years shall have each individual loss limited to $500,000 for experience rating.

C. No provider shall pay more than 50% in penalty.

D. As in the physician classes, losses shall be valued as of 90 days prior to renewal of coverage. Any changes in value after that date shall be considered in the following years' rating.

E. Each provider shall be supplied with a copy of their worksheet, so that they may review losses and surcharge records for accuracy.

F. In the event of a complete change of corporate ownership, the Fund may, at its discretion, amend the experience rating basis of the new entity to unity pending development of data by the new entity. Each such entity desiring such a change must make individual submission to the Fund. The new entities shall begin new experience ratings after completing one policy year under the new ownership.