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I. Medical Remuneration Receivables[1] Medical Remuneration Claims

1. Outline of Medical Remuneration Claims

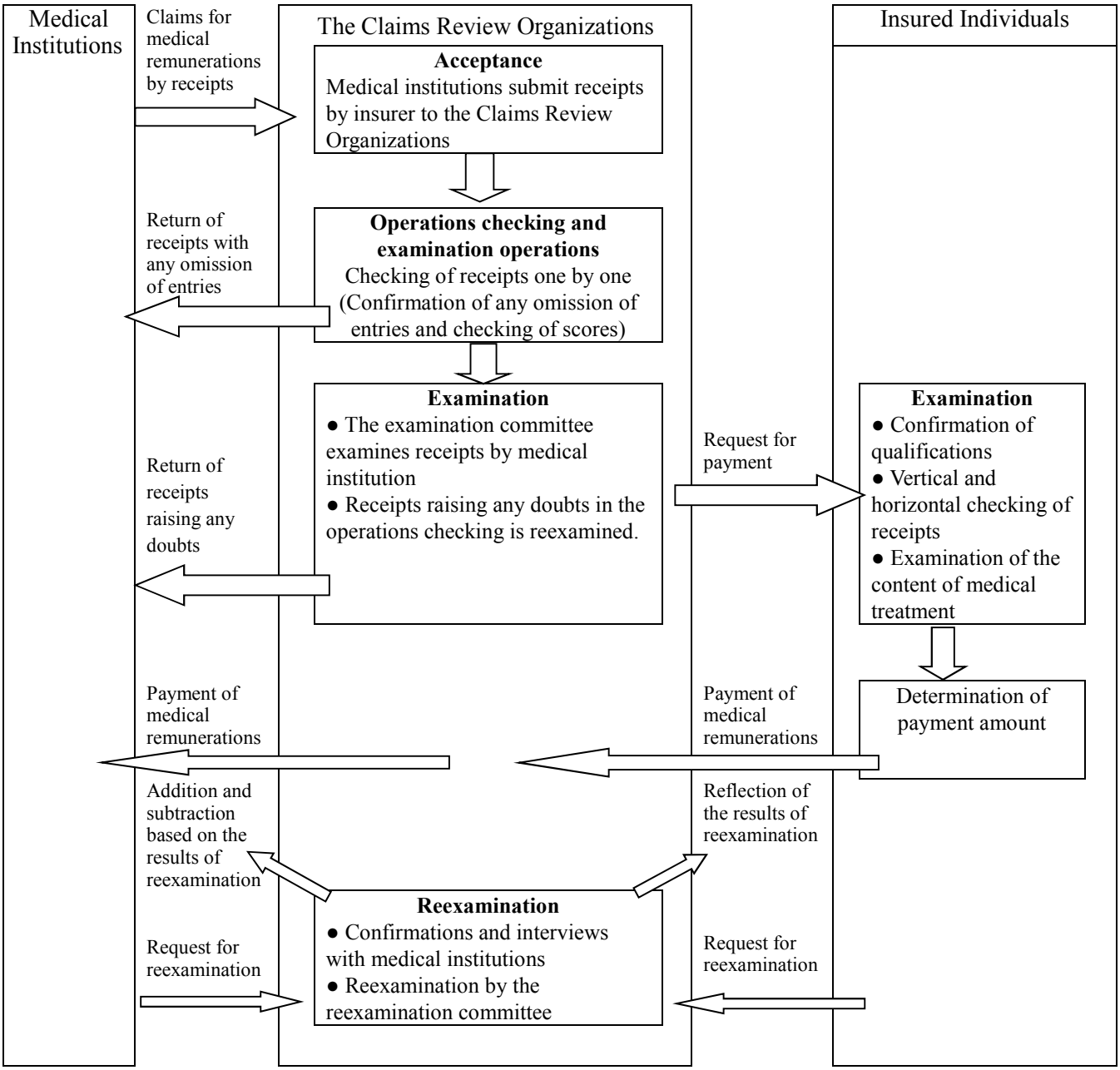
When an insurance medical institution gives medical cares to insured individuals and to their dependents, the medical institution has a claim on the Health Insurance Claims Review & Reimbursement Services or a National Health Insurance Organization (hereinafter collectively called "the Claims Review Organizations.") for payment of the medical remunerations from the Claims Review Organizations as compensation of the medical care services. This claim is referred to as a "medical remuneration claim".

The medical institution sends certificates of medical remunerations (hereinafter called "receipt") to the Claims Review Organizations until the 10th day of the next month of having provided medical care services and then makes a claim on the Claims Review Organizations for the medical fees excluding those paid individually by insured individuals at their own cost. The Claims Review Organizations examine whether the receipts, by which the medical institution has made a claim for the medical fees, are valid and appropriate in compliance with the rules on insurance medical institutions and persons in charge of medical cares (hereinafter called "rules on insurance medical persons in charge of medical cares") as stipulated in Article 70 and 72 of the Health Insurance Law, and then requests the insurers to pay the medical fees. The insurers themselves also examine the receipts to determine the payment amount and then pay the medical remunerations to the Claims Review Organizations with insurance premiums as resources. The medical remunerations paid by the insurers to the Claims Review Organizations are transferred to the medical institution by the Claims Review Organizations.

As described above, payments of medical remunerations by the Claims Review Organizations to medical institutions take form of medical remuneration revenues from the insurers as resources, thereby raising a problem on who is the debtor of medical remuneration claims. In this context, the Supreme Court made the following judgment on December 20, 1973: When an insurer entrusts the Health Insurance Claims Review & Reimbursement Services with payments of medical remunerations, it undertakes the legal obligations to pay them to persons in charge of insurance medical cares in its own name and based on its own examinations; and when an insurer entrusts a National Health Insurance Organizations with examinations and payments of medical remunerations, it also undertakes the obligations to pay them to medical institutions in charge of insurance medical cares. The judgment made it clear that the Claims Review Organizations are the debtors of medical remuneration claims and dispensing remuneration claims.

[1] The same concept basically applies to the credit rating of dispensing remuneration claims. For benefit claims for nursing-care costs, see the reference report under the title of "Problems of the Securitization of Benefit Claims for Nursing-care Costs".

Figure1: Flows of medical remuneration claims, examinations, and payments



2. Creditworthiness of the medical remuneration examination and payment bodies and creditworthiness of medical remuneration claims

(1) The Health Insurance Claims Review & Reimbursement Services

[Profile]

The Health Insurance Claims Review & Reimbursement Services (hereinafter called "HICRRS") is a special public corporation. It was established in 1948 following the enactment of the Law on Health Insurance Claims Review & Reimbursement Services. Based on the entrustment by individual

insurers except for those of the National Health Insurance, HICRRS makes examinations and payments of medical remunerations as applied for by insurance medical institutions. Since October 2003 at which time the law on HICRRS was partially revised, HICRRS has been changed to a private corporation.

[Organization and Examination System]

HICRRS has its Headquarters in Tokyo and establishes the executive board, the members of which include no more than 17 board members (sixteen representatives from the insurers, insured individuals, persons in charge of medical cares, and public-interest persons with four representatives from each interest group as of April 2017). HICRRS also places its branches in all the prefectures. Each branch establishes the administration board to discuss its operations management. Like the executive board, the administration board is comprised of the representatives from the insurers, insured individuals, and persons in charge of medical cares, as well as the public-interest representatives with the same number of members from each interest group (two from each).

In order to examine the certificate of medical remunerations (receipt), a “special examination committee” is organized in the Headquarters, while the “examination committee” is established in each branch. The examination committee of each branch is composed of the representatives from three groups of the persons in charge of medical cares, insurers, and academic experts with the same number of members from each group. One representative’s term of office is two years. Under its control, the examination committee organizes the management committee as well as the examination specialized committee, reexamination committee, dispensing examination committee, etc. There is a scheme in which the receipts marking high scores equal to or more than certain scores, among others, are examined by the examination specialized committee. (The special examination committee of the Headquarters examines the receipts marking 400,000 scores or more and those of dental treatment fees marking 200,000 scores.)

[Examination Results]

HICRRS achieved the following examination results for fiscal 2015 (period from May 2015 to April 2016) on a definite basis: The total number of examinations was 682,960,000 (a year-on-year increase of 3.7%). Out of 682,960,000 examinations, the number of examinations of medical treatment remunerations was 553,360,000 (a year-on-year increase of 3.7%).

[Evaluation of Creditworthiness of Medical Remuneration Claims]

HICRRS pays medical remunerations to each medical institution with the medical remunerations from the insurers as resources, and so the solvency of HICRRS entirely depends on the conditions of medical remunerations received from the insurers. The receipt percentage of medical remunerations from the mutual aid associations or the health insurance associations during a receipt period is in the

ninety-nine range staying at a high level. HICRRS takes responses to any delay of payment of medical remunerations by an insurer in such a manner that HICRRS makes a withdrawal from the trust money as received preliminarily from the insurer and from the basic fund.

(2) National Health Insurance Organizations

[Profile]

A National Health Insurance Organization (hereinafter called "NHIO") is a public corporation jointly established by the insurers (cities, towns and villages as well as national health insurance associations) based on the provisions of Article 83 of the National Health Insurance Law. There is one NHIO in each prefecture. Each NHIO is obliged to obtain the approval of its establishment from the governor of each prefecture and to submit its budgets, account settlements, etc. to the governor that has the supervisory authority on NHIO.

If two thirds or more of the member insurers in a district (city, town, or village) participate in NHIO, all the rest of the insurers also become the members of NHIO in that district. The medical remuneration examination committee is to be organized under NHIO.

[Examination Procedures and Financial Resources]

Each prefecture independently manages NHIO. Just like HICRRS, also in the case of NHIO, the examination committee composed of the three groups (the persons in charge of medical cares, insurers, and academic experts) is required to hold discussions on examinations of receipts. HICRRS and NHIO of each prefecture have many other common points. There were 550,000,000 definite payments of medical remunerations by NHIOs in the fiscal year 2015.

High-value receipts are examined by the special examination committee as organized by the All-Japan Federation of National Health Insurance Organizations, which is comprised of NHIO as its members.

[Evaluation of Creditworthiness of Medical Remuneration Claims]

Like HICRRS, in the case of each NHIO, there is also a scheme in which payments of medical remunerations to each medical institution entirely depends on the conditions of medical remunerations received from the insurers, namely, national health insurances of municipality and national health insurance associations. The receipt percentage of medical remunerations received from the insurers has declined year by year. If any insurer delays its payment of medical remunerations, each NHIO gets a loan from financial institutions in response to that case.

[Overall Evaluation]

There are requests to the deregulation committee, etc. for enhancement of the insurers' functions including permission of their examinations of receipts. However, it is not easy to construct an organizational system that ensures smooth and efficient processing of more than 1,000 million examinations and payments of medical remunerations on a yearly basis by the two examination bodies (HICRRS and NHIO) as described above.

In Japan, the universal health insurance system is a given fact, and so it is expected that the medical remuneration scheme based on the current social insurance system will be maintained.

Judging from these points in a comprehensive manner, HICRRS and NHIO being two medical remunerations examination and payment bodies are deemed to have quasi-creditworthiness of the Japanese government.

II. Risks of Medical Remuneration Claims

1. Current Claim and Future Claim

With attention focused on the process of medical treatment/care (a) claim for medical remuneration, medical remuneration claims are classified into the following three types.

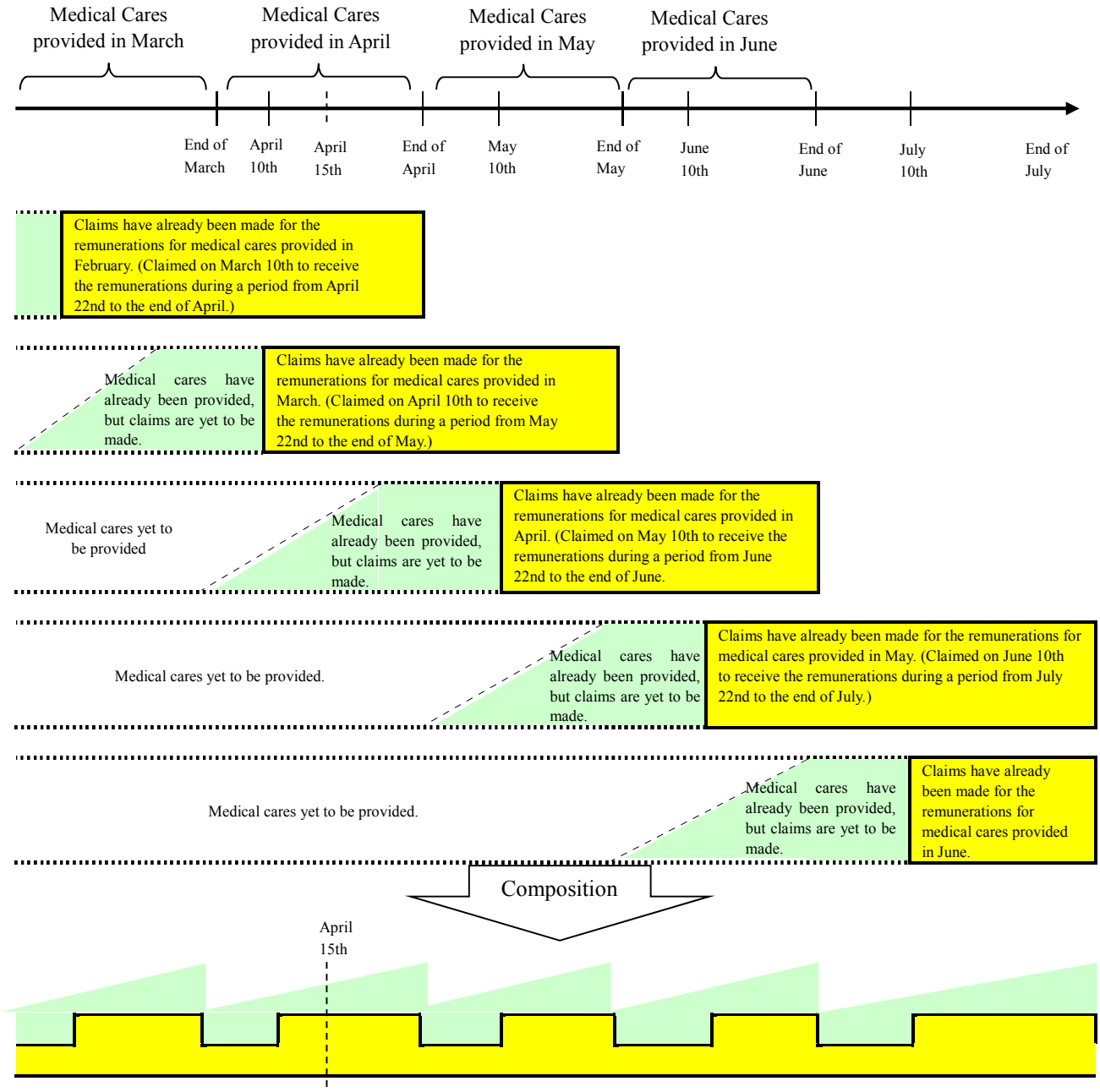
A current claim of Type (b) produces a cash flow to the highest degree of certainty and a future claim of Type (c) produces a cash flow to the lowest degree of certainty.

(a) Current claims (in the case where medical cares have already been provided and claims for the medical remunerations have already been made) (the yellow-colored part of the table below)

(b) Claims yet to be made in the case where medical cares have already been provided (the light-green-colored part of the table below)

(c) Future claims (in the case where medical cares are yet to be provided) (the white-colored part of the table below)

Figure 2: Relation between “Elapse of Time” and “Medical Remuneration Claims”



2. Risks of Medical Remuneration Claims (Current Claims)

(1) False Claims

If any false claims including claims for medical remunerations in excess of the actual medical fees are detected in any medical institution being the originator, there is a risk that the Claims Review Organizations may decrease the payment amount of medical remunerations as a setoff for the overpaid amount due to the false claim. Regardless of whether or not the medical remuneration claims transferred to the securitization vehicle are based on false claims, it is impossible to completely avoid

the risk that the payment amount of medical remunerations may decrease, unless the Claims Review Organizations give their consent with no objection to the transfer of the claims.

The enforcement regulations of the Medical Care Law stipulate a standard number of medical doctors and that of nurses corresponding to an average number of patients for one day and a number of allowable hospital beds. However, many hospitals are unable to secure the standard number of medical doctors as required. The medical remuneration unit price is determined according to the number of medical doctors as notified by a hospital. If the number of medical doctors on the active list is less than 60% of the standard number of medical doctors, any hospital should reduce medical remunerations and should make a claim for the balance amount of medical remunerations after the reduction. Any hospital that has notified a number of medical doctors in excess of those on the active list has accordingly made a false claim for medical remunerations (even though such notification was not intended to make a claim for medical remunerations in excess of the actual medical fees).

As the result of an on-site inspection (audit) of a hospital conducted by the social insurance office established in each prefecture, if a fact of any false claim is confirmed, a claim for the return of dishonestly received medical remunerations will be made against the hospital. If a malicious claim is made, its designation as an insurance medical institution will be cancelled and so the hospital will be taken over by a new management body or it does nothing but close down[2].

Even when a fact of any false claim is confirmed, the Claims Review Organizations will not suddenly decrease the amount of medical remunerations payable to the securitization vehicle in the next month as a setoff for the overpaid amount due to the false claim in a usual case. First of all, a claim for the return of dishonestly claimed and received medical remunerations will be made against the hospital. Even when a decision is made to cancel its designation as an insurance medical institution, a grace period of one month is often set before actual cancellation of its designation as an insurance medical hospital and before finding of any hospital(s) to which the hospitalized patients will be transferred and finding of a new business manager. A medical corporation will not become bankrupt immediately after the decision is made to cancel its designation as an insurance medical institution. In the case where a medical corporation becomes bankrupt and the medical institution has no financial resources to refund the falsely claimed and received medical remunerations, there remains the possibility that the amount of medical remunerations payable to the securitization vehicle may be reduced as a setoff for the overpaid amount due to the false claim. If the amount of falsely claimed medical remunerations is not covered by the reduction of medical remunerations to be paid later as a setoff for that amount of money, there is a possibility that the Claims Review Organizations may claim against the securitization vehicle a restitution of undue profits on the medical remunerations, which the Claims Review Organizations have already paid to it, based on the civil code (theoretically speaking).

[2] In an over-bed region where the number of actual hospital beds exceeds the number of necessary hospital beds as stipulated in the Medical Care Law, it is prohibited for a different business manager to take over the management of any medical institution whose designation as an insurance medical institution has been cancelled as a general rule, and so the medical institution will close down after the transfer of hospitalized patients to any other hospital(s).

(2) Dilution

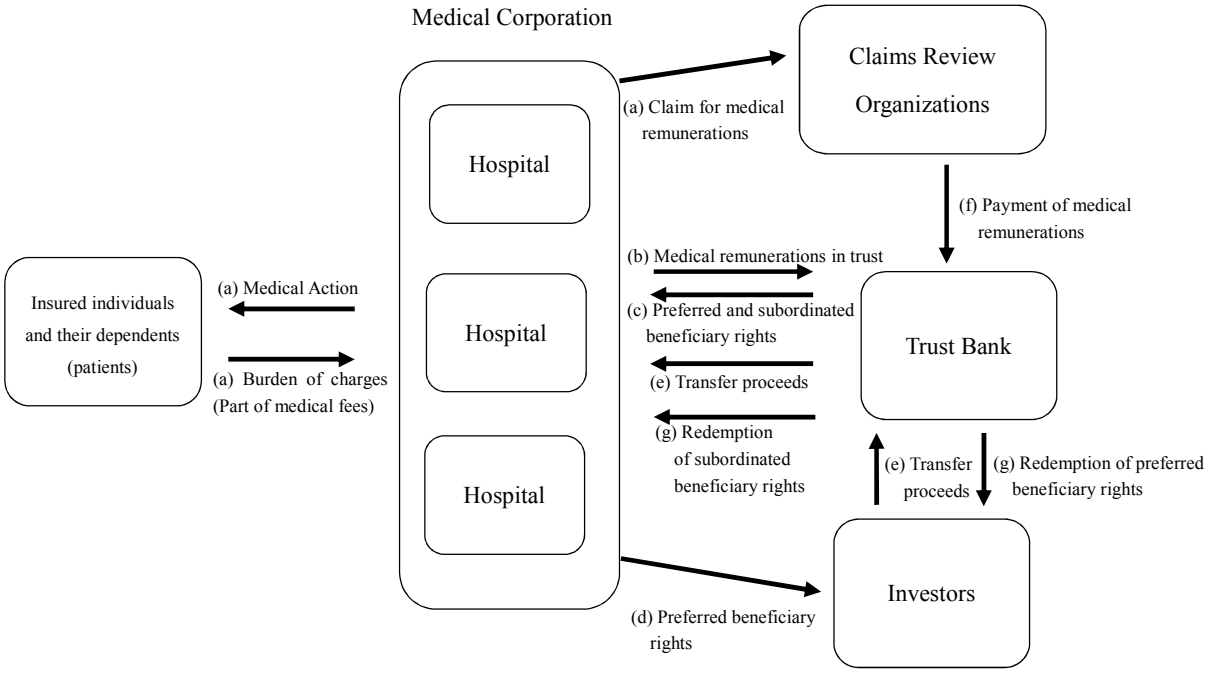
Regarding medical remunerations, the following cases occur constantly: Medical remunerations are returned, if there are any clerical errors in the content of receipts including omissions of entries, errors in the entries (different insurer, different insurance card number, etc.) and if there are any descriptive errors in the content of medical cares; and the payment amount (score) of medical remunerations is reduced as the result of their examination by the Claims Review Organizations in compliance with the rules on insurance medical persons in charge of medical cares. Besides, if the examination results of some receipts are not notified before the end of the next month of having claimed medical remunerations (the medial remunerations will be paid in the month after the next month or even later), the medical remunerations will be diluted because the previous payment amount of medical remunerations to be decreased due to the insurer's request for the reexamination will be set off against the payment amount of medical remunerations, etc. for the current month. (The insurer can later make a request for the reexamination of receipts, the payment of which the insurer has already completed, if they have any doubts. If the reduction of the payment amount of medical remunerations is approved, the payment amount to be decreased will be set off against the payment amount of medical remunerations for the current month.)

III. Framework of Credit Rating

1. Securitization Scheme on which this thesis is premised:

The following figure illustrates an ordinary securitization scheme. The simplest trust method is taken as an example.

Figure3: Scheme Chart of Trust Method



(a) A medical corporation (hospital) provides insurance medical cares to insured individuals and their dependants. It collects their burden charges (part of the medical fees) at the window. It sends the receipt to the Claims Review Organizations to make a claim for the balance amount of the medical remunerations subject to the insurance.

(b) The medical corporation transfers its holding medical remuneration claims in trust to a trust bank.

(c) Each time the medical corporation makes a claim on the Claims Review Organizations for medical remunerations every month, the trust bank issues preferred beneficiary rights and subordinated beneficiary rights for that month[3].

(d) The preferred beneficiary rights are transferred to investors and the subordinated beneficiary rights are retained by the medical corporation.

(e) The medical corporation receives the transfer proceeds of the preferred beneficiary rights paid by the investors.

(f) On the due date of a medical remuneration claim, the Claims Review Organizations pay directly to the trust bank the amount of medical remunerations (after deduction of the amount of medical remunerations to be returned due to the examination).

(g) The principals of preferred beneficiary rights are delivered to the investors and the balance amount is appropriated for the redemption of subordinated beneficiary rights.

In addition to the above, in a scheme where a SPC is used as a securitization vehicle instead of a trust, a medical corporation assigns its medical remuneration claims to the SPC. Each time when the medical corporation makes a claim on the Claims Review Organizations to pay for the medical services every month, the SPC takes out an asset-backed loan backed by these receivables.

Since securitization of medical remuneration receivables is conducted repeatedly and continuously with the same content for both trust method and SPC method (securitization program), in the case of a rating for securitization of medical remuneration receivables, JCR in principle assigns a rating to securitization programs under which securitization products can be issued for a certain period (program rating). When assigning a program rating, it is necessary that conditions including period of program, maximum amount, subordination ratio to be set, representations and warranties for accuracy of materials to be received by JCR, etc. be specified in the securitization related agreements.

[3] Medical remuneration claims for one to three years are collectively transferred to the trust bank for convenience of fulfilling the opposing requirements. Transfer of preferred beneficiary rights often takes form as follows: Each time the medical corporation (hospital) makes a claim on the Claims Review Organizations for medical remunerations for the current month and the amount of the medical remuneration claim is determined, the preferred beneficiary rights are transferred to investors on a monthly basis.

2. Framework of Credit Rating of Claims yet to be made for remunerations for medical cares that have already been provided

(1) Certainty of payment of medical remuneration claims

As described in Paragraph 2 of Section I, above, the Claims Review Organizations serving as the medical remuneration examination and payment bodies are deemed to have quasi-creditworthiness of the Japanese government. It is therefore possible to give an equivalent credit rating to securitization products of medical remuneration claims.

(2) Screening of medical corporations

Any medical remuneration claim bears the biggest risk of a false claim. For this reason, if necessary, due diligence of the following points (see the "Major Due Diligence Items" at the end of this thesis) is conducted by an accounting office or an audit corporation. Medical remuneration claims subject to the credit rating are limited to those of the medial corporations serving as an originator with no problem reported by them.

- A medical corporation has an appropriate operations system.
- A medical corporation satisfies the medical facility criteria.
- A medical corporation has not fallen into any credit uncertainty and any cash-flow problem.

The medical remuneration claims of a medical corporation serving as an originator that is deemed to have problems in view of the points as described above are likely to be treated as claims unsuitable for the credit rating in some cases. Even when a credit rating is given to such claims, it may sometime be a low credit rating. In the following scheme, however, the screening requirements can be eased on the condition that money amounts of medical remuneration claims by originator are dispersed: Many originators transfer their medial remuneration claims to one securitization vehicle with subordinated beneficiary rights and subordinated beneficiary interests shared by and between the originators.

(3) Responses to dilution risk

There is a risk that by a setoff against medical remunerations due to returns, point-deduction, continued examination, and a claim for restitution of overpayment by an insurer, the credit transfer of or the credit amount of medical remuneration claims being resources for the redemption of preferred beneficiary rights may be delayed or deducted in part on the redemption date. Responses are taken to this risk in such a manner that a stress test is conducted on the basis of historical data, according to the result of which excess collateral suitable for the credit rating is provided.

In case that JCR evaluates the credit rating of preferred beneficiary rights as "J-1+" equivalent to the creditworthiness of the Claims Review Organizations, a stress magnification is applied and a credit enhancement level is set according to the percentage of the amount of money yet to be received (uncollected money) in relation to the claim amount of medical remunerations on a monthly basis (taking into account all the dilutive factors including returns, decreases in the amount of money, etc.,

the respective percentages are calculated for the Health Insurance Claims Review & Reimbursement Services and for a National Health Insurance Organization). A stress magnification is set with threefold as a minimum level and in consideration of the following items, the final level of excess collateral is determined: volatility of historical data; dispersion degree of securitization claims (the number of hospitals and a percentage of the amount of money by each hospital); the number of claims, financial condition or operational ability of each medical corporation; large returns or no large returns; and other items as confirmed at the due diligence meeting.

Certainty of the timely redemption of the principals of and the timely payment of dividends of profits on preferred beneficiary rights is the main factor that determines the credit rating of short-term trust beneficiary rights. If the credit amount of money has significantly decreased this month, the timely payment (redemption) cannot be maintained. In the case of one facility, if the amount of money yet to be received (uncollected money) has greatly increased this month, it is impossible to cover the lack of money by cash flows of other facilities. In this context, for the calculation of an excess collateral ratio, it is important to take into consideration the number of relevant facilities and the dispersion degree of the amount of money.

(4) Other Points of Contention

(a) Duplicated Transfer of Claims and Fulfillment of Opposing Requirements

In a normal case of transfer of medical remuneration claims, a medial institution, which is an assignor of the claims, prepares a notification directed to the Claims Review Organizations pursuant to Article 467, Paragraph 1 of the civil code and has on the notification the transfer date affixed by a notary public as the officially-attested date of transfer. It notifies the Claims Review Organizations of the transfer of the claims with the notification as a deed bearing an officially-attested date pursuant to Article 467, Paragraph 2 of the civil code. If the same claims have already been transferred or offered as collateral to a third party and the opposing requirements have been fulfilled by notification, these facts will be detected at the time of confirming the transfer of the claims with the Claims Review Organizations (before payment).

(b) Denegation

The necessary denegation conditions are limited by the revised bankruptcy law and the revised civil rehabilitation law as implemented on May 1, 2005. Any transfer of claims in trust and any transfer of beneficiary rights are not subject to the denegation, regardless of the time of the transfer, based on the premise that the transfer value is appropriate, unless the consignor has an intention to decrease the absolute value of assets, for which it is responsible, by consuming and concealing the transfer value, etc. and the investors as well as their representatives are aware of that intention of the consignor.

3. Claims yet to be made in the case where medical cares have already been provided

Taking a look at the point in time on April 15th in Figure 2, there are three types of claims for the remunerations for medical cares that have already been provided: i) claims made on March 10th for the remunerations for medical cares provided in February; ii) claims made on April 10th for the remunerations for medical cares provided in March; and iii) claims yet to be made for the remunerations for medical cares provided until April 15th. Based on the premise that claims yet to be made for the remunerations for medical cares that have already been provided are treated as current claims[4], if claims for medical remunerations are liquidated every month beginning the first securitization scheduled for April 15th, it is possible to deem that there are always current claims for a period of at least one month and half on and after April 15th , even excluding those for the remunerations for medical cares provided in February with a residual period of 15 days only.

In the case of securitization of claims for medical remunerations including those yet to be made in the case where medical cares have already been provided, the following requirements in additions to the points of contention as described in Paragraph 2 of Section III must be fulfilled for assigning a credit rating. In the following scheme, however, even when the amount of collected money is zero (0) from the claims as concerned with one originator, it is possible to secure the resources for the redemption of the principals of securitization products subject to the credit rating with the collected money from the claims as concerned with other originators: Many originators transfer their medial remuneration claims to one securitization vehicle with subordinated beneficiary rights and subordinated beneficiary interests shared by and between the originators. For this reason, it is possible to ease the following requirements, when money amounts of medical remuneration claims by originator are dispersed and if it is admitted that the appropriate setting of the levels of subordinated beneficiary rights and subordinated beneficiary interests covers the risk inherent in claims yet to be made in the case where medical cares have already been provided.

- It is required to obtain a written legal opinion to the effect that any medical remuneration claim is understood to take effective form at the point in time when medical actions have been taken.
- In order to prevent any fraud aimed at the providers of funds including a claim for medical remunerations in excess of actual medical fees, it is required to add items to the representations and warranties, and to make the screening criteria more rigorous.
- In case that any claim for medical remunerations is not made by a medical corporation due to its bankruptcy, it is required to arrange a backup servicer, a business agent to make claims for

[4] For the judgment of when any medical remuneration claim arises, the judgment made on March 23, 1981 by the Osaka District Court states as follows: A medical remuneration claim as retained by an insurance medical institution is understood to have the same nature of a claim for the remuneration for the consigned operations and accordingly the claim for the remuneration for the consigned operations arises when the consignee has implemented the operations in compliance with the consignment purpose. Meanwhile, the judgment made on May 27, 1983 by the Osaka Supreme Court states as follows: When a medical institution has implemented the operations in compliance with the consignment purpose as described earlier, so to speak, when it has provided medical cares in conformity with the applicable laws and regulations, the medical remuneration claim arises accordingly.

medical remunerations on behalf of the medical corporation. Besides, in consideration of the time lag until the backup servicer starts the operation, it is required to set a tail period (time lag) of one to two months between the scheduled maturity and the final maturity of the redemption of trust beneficiary rights.

- Based on the assumption (i) that there arise some receipts in a certain amount of money, by which a claim for medical remunerations will not be made in the next month and (ii) that it is impossible to obtain detailed symptoms of doctors in the case of bankruptcy of an medical corporation, it is required to set the excess collateral for a second-month claim for medical remunerations at a high level.

[Main Materials JCR Requests for Rating]

1. Historical Data
2. Complete Set of Final Tax Return Forms (Attached table, Financial statements, Itemized statement)
3. Results of On-site Inspection (Results of on-site inspection in accordance with Article 25 of Medical Service Law)
   - Table of facilities
   - Reports on on-site inspection findings and improvement (plan)
4. Certificate of Tax Payment or Statement of Payment (Corporate tax, Corporate prefectural and municipal tax, Corporate enterprise tax, and Consumption tax)
5. Notification of Designation of Medical Institutions Authorized to Treat Patients with Health Insurance Coverage
6. Materials Showing Sufficiency Rate of Doctors and Nurses
7. Data on Monthly Amount Claimed and Paid Amount (by NHIO and HICRRS)

[Major Due Diligence Items]

1. Facility Criteria
   - Conditions of satisfaction of doctors (confirmation of real existence of doctors)
   - Conditions of satisfaction of nurses (confirmation of real existence of nurses)
   - Conditions of satisfaction of facility criteria

2. Historical Data
   - Correctness and accuracy of a claimed/credited amount of money, etc.
   - Causes of and responses to a large sum of returns and causes of sharp increases and decreases in the money amount of claims
   - Reconciliation (matching) of receipts, etc. with a list of claims for medical remunerations by patient (or any quasi data)
   - Existence/nonexistence pf high-value medical cares
   - Relationship with a medical association and a faculty of medicine
   - Effects of the revision of medical remunerations

3. Organization of Medical Professions Division
   - The number of personnel, years of experience, job turnover ratio, and external entrusted company in the medical professions division
   - Years of experience, etc. of personnel to input receipts, personnel in charge of checking receipts, and personnel responsible for the medical professions division

- Training program and frequency
- Existence of a medical remunerations claim manual
- Cause analysis of and responses to returns and deductions of points
- Effects of the most recent revision of medial remunerations on the operations of making a claim for medical remunerations

4. Financial Conditions and Management Results
   - Conditions of management and conditions of tax payments
   - Companies and individuals to which money is lent, and those from which money is borrowed
   - Relationship with the president, a medical service corporation, etc.

5. Other Items
   - Conditions of preventive measures for medical accidents (existence and nonexistence of a safety management committee, organization of the committee if any, existence and nonexistence of personnel in charge of safety management, and responses to in-hospital infection)
   - Results of the most recent on-site inspection (Article 25 of the Medical Care Law) and conditions of improvements
   - Compliance program with various kinds of laws and regulations (training conditions, training frequency, etc.)
   - Conditions of getting a certification from the Japan Council for Quality Health Care and from ISO.

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