REPORT ON EXAMINATION

OF THE

STEUBEN AREA

SCHOOL EMPLOYEES' BENEFIT PLAN

AS OF

JUNE 30, 2014

DATE OF REPORT **OCTOBER 4, 2016**

EXAMINER **CHARLES J. McBURNIE**

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October 4, 2016

Honorable Maria T. Vullo
Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 31279, dated March 13, 2015, attached hereto, I have made an examination into the condition and affairs of Steuben Area Schools Employees' Benefit Plan, a municipal cooperative health benefit plan certified pursuant to the provisions of Article 47 of the New York Insurance Law, as of June 30, 2014, and respectfully submit the following report thereon.

The examination was conducted at the home office of Steuben Area Schools Employees' Benefit Plan located at 9579 Vocational Drive, Painted Post, New York.

Wherever the designations the "Plan" or "SASEBP" appear herein, without qualification, they should be understood to indicate the Steuben Area Schools Employees' Benefit Plan.

Wherever the designation the "Department" appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

1. SCOPE OF EXAMINATION

The previous examination of the Plan was conducted as of June 30, 2010. This examination of the Plan was a combined financial and market conduct examination and covered the five-year period from July 1, 2010 through June 30, 2014.

The financial component of the examination was conducted on a risk-focused basis in accordance with the provisions of the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2015 Edition* (the "Handbook"). The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiner, transactions occurring subsequent to June 30, 2014 were also reviewed.

The examiner planned and performed the examination to evaluate the Plan's current financial condition, as well as identify prospective risks that may threaten the future solvency of SASEBP.

The examiner identified key processes, assessed the risks within those processes and assessed the internal control systems and procedures used to mitigate those risks. The examination also included an assessment of the principles used and significant estimates made by management, an evaluation of the overall financial statement presentation, and determined management's compliance with the Department's statutes and guidelines, Statutory Accounting Principles, as adopted by the Department and NAIC Annual Statement instructions.

Information concerning the Plan's organizational structure, business approach and control environment were utilized to develop the examination approach. The examination evaluated the Plan's risks and management activities in accordance with the NAIC's nine branded risk categories.

These categories are as follows:

- Pricing/Underwriting
- Reserving
- Operational
- Strategic
- Credit
- Market
- Liquidity
- Legal
- Reputational

The Plan was audited annually, for the years 2010 through 2014, by the accounting firm of Ciaschi, Dietershagen, Little, Mickelson & Company, LLP. The Plan received an unmodified opinion in each of those years. Certain audit work papers of Ciaschi, Dietershagen, Little, Mickelson & Company, LLP were reviewed and relied upon in conjunction with this examination.

This report on examination is confined to financial statements and comments on those matters which involve departures from laws, regulations or rules, or which require explanation or description.

A review was also made to ascertain what action was taken by the Plan with regard to comments and recommendations contained in the prior report on examination.

2. DESCRIPTION OF THE PLAN

Steuben-Allegany Board of Cooperative Educational Services ("BOCES") and its eight (8) original member school districts ("Participants") formed a consortium, effective July 1, 1981. The purpose of the consortium was to provide for the efficient and economic evaluation, processing, administration and payment of health benefits through self-insurance. The Plan provides benefits to covered employees and their eligible dependents as defined in the plan booklet.

On June 1, 2001, the Plan was issued a certificate of authority by the then Superintendent of Insurance under Article 47 of the New York Insurance Law. Pursuant to such certificate of authority, the Participants have agreed to share the costs and assume the liabilities for medical, surgical, prescription drugs, and hospital benefits provided to covered employees (including retirees) and their dependents.

On February 10, 2005, the Commissioner of Education ordered the merger of Steuben-Allegany BOCES and Schuyler-Chemung Tioga BOCES. Effective July 1, 2006, the common name of the merged BOCES became the Greater Southern Tier BOCES. Steuben-Allegany BOCES withdrew from the Plan and as a result of such withdrawal, all of Steuben-Allegany BOCES employees covered under the Plan were terminated from the Plan effective July 1, 2006.

The Hornell City School District ("Hornell") joined the Plan on February 1, 2006 under a contractual agreement, which required Hornell to make a $1,517,822 reserve

contribution buy-in, paid in five installments. An initial payment of $126,486 was received in the 2006 plan year and $347,384 was received in 2007. The Plan deferred the remaining three payments of $347,384, due July 2007 through July 2009, for one additional year, with the final payment due in 2010 with no interest consideration. On September 15, 2008, the agreement between the Plan and Hornell for the $1,517,822 reserve contribution buy-in was revised to reduce the total buy-in amount to $1,308,700. Hornell paid its contributions in full as of June 30, 2010.

There are currently eight school districts participating in the Plan. The Plan Participants are as follows:

Arkport Central School
Avoca Central School
Campbell-Savona Central School
Canaseraga Central School
Canisteo-Greenwood Central School
Hammondsport Central School
Hornell City School District
Jasper-Troupsburg Central School

A Corporate Governance

Pursuant to the Plan's Municipal Cooperation Agreement, management of the Plan is to be vested in a governing board ("board"), comprised of one representative from each participating school district.

The governing board of the Plan as of June 30, 2014 was as follows:

Name and Residence	Affiliation
Timothy Allard Campbell, New York	Business Manager, Campbell-Savona Central School
Kyle Bower Hammondsport, New York	Superintendent, Hammondsport Central School
Gay Fairbrother Avoca, New York	Business Manager, Avoca Central School
Chad Groff Canaseraga, New York	Superintendent, Canaseraga Central School
Theresa McKenna Canisteo, New York	Business Manager, Canisteo-Greenwood Central School
Michael Mead Jasper, New York	Superintendent, Jasper-Troupsburg Central School
Glenn Niles Arkport, New York	Superintendent, Arkport Central School
Douglas Wyant Hornell, New York	Superintendent, Hornell City Central School

*Effective April 1, 2014 Chad Groff, Superintendent, replaced Michael Gill as the representative of Canaseraga Central School on the governing board.

*Effective July 2014 Michael Mead, Superintendent, replaced Chad Groff as the representative of Jasper-Troupsburg Central School on the governing board.

*Effective July 1, 2015, Chad Groff was elected as the Steuben Area Schools Employees Benefit Plan Chairman (President)

* Effective July 1, 2015, Kyle Bower was elected as the Steuben Area Schools Employees' Benefit Plan Vice-Chairman.

According to the Municipal Cooperation Agreement, the governing board shall meet quarterly in the months of October, January, April, and July. The board may call special meetings at any time. The governing board scheduled regular quarterly meetings

during the period under examination. The minutes of all meetings of the governing board during the examination period were reviewed. All such meetings were well attended.

The officers of the Plan as of June 30, 2014 were as follows:

Officers	Title
Kyle Bower	Chair & President
Timothy Allard	Chief Financial Officer
Rebecca Towner	Treasurer & Secretary

Section 4705(a) of the New York Insurance Law states in part:

> "(a) The municipal cooperation agreement, under which the municipal cooperative health plan is established and maintained, and any amendment thereto, shall be approved by each participating municipal corporation by majority vote of each such corporation's governing body,…"

A review of the municipal cooperation agreement, under which the municipal cooperative health plan is established and maintained, determined that said agreement was not approved by each participating municipal corporation by majority vote of each such corporation's governing body.

It is recommended that the Plan comply with Section 4705(a) of the New York Insurance Law by ensuring that the municipal cooperation agreement under which the municipal cooperative health plan is established and maintained be approved by each participating municipal corporation by majority vote of each such corporation's governing body.

A review of the Plan's corporate governance structure revealed that the governing board did not adopt written procedures that would allow the board to obtain certification, annually, from either an internal auditor or independent CPA that the responsible officers have implemented the procedures adopted by the board, and from the Plan's general counsel, a statement that the Plan's current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with applicable statutes, rules and regulations.

It is recommended that, as a prudent business practice, the board adopt written procedures that would require the board to obtain an annual certification, either from an internal auditor, or the Plan's independent CPA firm and the Plan's general counsel, that the Plan's responsible officers have implemented procedures adopted by the board and that the Plan's current claims adjudication procedures, including those set forth in current claims manuals, are in accordance with applicable statutes, rules and regulations.

Also, as part of the corporate governance structure, the Plan's responsibilities include the overseeing of management's handling of the claims adjudication process which extends to outside parties whom, pursuant to an agreement with the Plan, perform claims adjudication procedures on behalf of the Plan.

It is recommended that, as prudent business practice, the Plan's board of governors obtain annual certifications from its third party claims administrators that

claims are being processed in accordance with the Plan Document and applicable statutes, rules and regulations.

B. Territory and Plan of Operation

The Plan provides hospital, medical and pharmacy benefits to eligible members and their dependents of the participating school districts in Steuben and Allegany counties within New York State. The Plan reported annual written premiums of $13,142,292 for the fiscal year ending June 30, 2014. The Plan's enrollment as of June 30, 2014 was 1,370. There was no significant change in membership throughout the examination period.

C. Stop-Loss Coverage

As required by Section 4707 of the New York Insurance Law, the Plan maintains both aggregate stop-loss coverage and specific stop-loss coverage. The provider of the stop-loss coverages is authorized in New York. The following is a summary of the Plan's stop-loss program as of June 30, 2014:

Type	Limits
Excess of loss (one layer)	100% of $1,000,000, excess of $250,000 per member, per contract year
Aggregate excess of loss	$1,000,000 excess of annual aggregate attachment point ($21,218,122), for the current contract period

D. Administrative Services Agreements

The Plan entered into contractual agreements with the following vendors that provided various administrative services to the Plan:

- Excellus Health Plan, Inc. ("Excellus") provides: processing of medical and hospital claims, administrative services, preparation and delivery of reports required under the administrative service agreement, medical review and managed care services, and maintenance of an adequate provider network.

- InformedRX maintains an electronic system for processing and paying prescription drug claims and furnishing related services through a network of pharmacies and other professional facilities for the purpose of administering the Plan's prescription drug benefit.

- Orville A. Boden, Jr., an independent consultant, performs consulting services for the Plan related to rates, benefits and enrollment. He assists in the review and revision of the plan benefit structure.

- The Segal Company ("Segal") performs actuarial services for the Plan. The firm certified the Plan's reserves in each of the years of the examination period.

- Ciaschi, Dietershagen, Little, Mickelson & Company, LLP provided accounting support and auditing services to the Plan during the examination period.

D. Annual Statement Preparation

A review of the annual statements filed during the period under examination revealed that the Plan failed to report the correct amounts from its June 30, 2012 annual statement, NY 4 Report #2-Statement of Revenue, Expenses and Net Worth, lines 11 and 18 to its June 30, 2014 annual statement, N.Y. Schedule H – Five Year Historical Data lines 8 and 9.

The Department requested that the Plan submit a revised Report #2 Statement of Revenue, Expenses and Net Worth, per its June 30, 2014 annual statement because the

Plan did not break- out the change in its Section 4706(a)(5) contingency reserve and failed to show how such change affected the Plan's retained earnings/fund balance.

The Plan was also requested to submit a revised Schedule H – Five Year Historical Data (NY13) relative to its June 30, 2014 annual statement filing as a result of the aforementioned Report No. 2 filing error.

Further, the Plan was required to submit a revised Schedule F – Claims Payable Analysis (NY11) relative to its June 30, 2014 annual statement filing. Such schedule was filed with several amounts reported incorrectly.

It is recommended that the Plan prepare and submit its annual statements and supporting schedules in accordance with the guidance prescribed in the NAIC annual statement instructions.

It is further recommended that the Plan exercise an increased level of care in the preparation of its annual statements.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following statements show the assets, liabilities, and surplus as of June 30, 2014, as contained in the Plan's 2014 filed annual statement, a condensed summary of operations and a reconciliation of the surplus account for each of the years under review by the examiner. The examiner's review of a sample of transactions did not reveal any differences which materially affected the Plan's financial condition as presented in its financial statements contained in the December 31, 2014 filed annual statement.

Independent Accountants

The firm of Ciaschi, Dietershagan, Little, Michelson & Company, LLP was retained by the Plan to audit the Plan's combined statutory basis statements of financial position as of December 31st of each year in the examination period, and the related statutory-basis statements of operations, surplus, and cash flows for the year then ended.

Ciaschi, Dietrshagan, Little, Michelson & Company, LLP concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the Plan at the respective audit dates. Balances reported in these audited financial statements were reconciled to the corresponding years' annual statements with no discrepancies noted.

Assets	
Cash and cash equivalents	$8,877,370
Claim deposit	169,480
Premium Receivable	49,730
Total Assets	$9,096,580
Liabilities	
Accounts payable	$5,150
Claims payable	$2,361,930
Total Liabilities	$2,367,080
Surplus	
Unassigned Funds (Surplus)	$5,809,540
Surplus per Section 4706(a)(5)	919,960
Total Surplus	$6,729,500
Total Liabilities and Surplus	$9,096,580

B. Statement of Revenues and Expenses and Change in Surplus

Surplus increased $497,427 during the five-year examination period, July 1, 2010 through June 30, 2014, detailed as follows:

Revenues:		
Premiums	$51,687,213	
Investment income	94,565	
Aggregate write-ins for other revenue	1,812,191	
Total revenues		$53,593,977
Expenses:		
Hospital and medical claims	$29,406,768	
Drug claims	19,282,522	
Claims liability	584,601	
Claims subtotal	49,273,891	
Reinsurance expenses net of recoveries	295,437	
Net claims incurred	$49,569,328	
Administrative expenses	$ 3,326,126	
Total expenses		$52,895,454
Net income		$ 698,523
Surplus, per report on examination, as of June 30, 2010		$ 6,232,073

	Increases In Surplus	Decreases In Surplus
Net income	$698,523	
Adjustment for incurred but not reported claims		$201,096

Net increase in Surplus	497,427
Surplus per report on examination, as of June 30, 2014	$6,729,500

4. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Plan conducts its business practices and fulfills its contractual obligations to subscribers and claimants. The review was general in nature and is not to be construed to encompass the more precise scope of a market conduct examination.

The general review was directed at practices of the Plan in the following areas:

(A) Claims review
(B) Policy forms/benefits
(C) Complaints
(D) Underwriting and rating

A. Claims Prompt Payment Review

A review to test for compliance with Section 3224-a of the New York Insurance Law (Prompt Payment Law) was performed by using a statistical sampling methodology covering claims submitted to the Plan during the period July 1, 2013 through June 30, 2014.

Section 3224-a(a) of the NYIL states:

> "Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy ("covered person") or make a payment to a health care provider is not reasonable clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within thirty days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or forty-five days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile".

The review of the Plan's submitted medical and hospital claims data for the period, July 1, 2013 through June 30, 2014 relative to compliance with Section 3224-a(a) of the New York Insurance Law revealed that potential violations of Section 3224-a(a) of the New York Insurance Law were reviewed through the isolation of all electronically submitted claims that were not adjudicated within 30 days of receipt. The result of the examiner's analysis revealed a population of 5,055 claims which met the aforementioned criteria. A sample of 167 claims was extracted from the aforementioned population and reviewed. Of this sample, there were 82 confirmed violations

The following chart illustrates the Plan's compliance with Section 3224-a(a) of the New York Insurance Law as determined by this examination:

Total claims population	**61,515**
Population of claims adjudicated after After 30 days of receipt	**5,055**
Sample Size	**167**

Number of claims with violations	**82**
Calculated violation rate	**49.10%**
Lower Violation Limit	**41.52%**
Upper Violation Limit	**56.68%**
Calculated claims in violation	**2,482**
Lower limit transactions in violation	**2,099**
Upper limit transactions in violation	**2,865**

Note: The lower and upper error limits represent the range of potential error (e.g., if 100 samples were selected, the rate of error would fall between these limits 95 times).

It is recommended that the Plan take steps to comply with the provisions of Section 3224-a(a) of the New York Insurance Law regarding the prompt payment of electronically submitted claims.

The examiner also conducted a review of claims, submitted by other than electronic means, which were not adjudicated within forty-five days of receipt. The result of the examiner's analysis for such non-electronic submitted claims revealed a population of 1,354 possible violations. A sample of 167 claims was extracted from the aforementioned population and reviewed. Of this sample, there were 80 confirmed violations.

The following chart illustrates the Plan's compliance with Section 3224-a(a) of the New York Insurance Law as determined by this examination:

Total claims population	61,515
Population of claims adjudicated after 45 days of receipt	1,354
Sample Size	167
Number of claims with violations	80
Calculated violation rate	47.90%
Lower Violation Limit	40.33%
Upper Violation Limit	55.48%
Calculated claims in violation	649
Lower limit transactions in violation	546
Upper limit transactions in violation	751

Note: The lower and upper error limits represent the range of potential error (e.g., if 100 samples were selected, the rate of error would fall between these limits 95 times).

It is recommended that the Plan take steps to comply with the provisions of Section 3224-a(a) of the New York Insurance Law regarding the prompt payment of non-electronically submitted claims.

Denied claims review

Section 3224-a(b) of the New York Insurance Law states in part:

> "(b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability or another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which

> services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty days of the receipt of the claim;"
>
> (1) That it is not obligated to pay the claim or make the medical payment, stating the specific reason why it is not liable; or
>
> (2) To request all additional information needed to determine liability to pay the claim or make the health care payment…"

The result of the examiner's analysis for claims which took more than thirty days from receipt to deny, revealed a population of 3,996 possible violations. A sample of 167 claims was extracted from the population and reviewed. Of this sample, there were 64 confirmed violations.

The following chart illustrates the Plan's compliance with Section 3224-a(b) of the New York Insurance Law as determined by this examination:

Total claim population	61,515
Population of claims adjudicated after After 30 days of receipt	3,996
Sample Size	167
Number of claims with violations	64
Calculated violation rate	38.32%

Lower Violation Limit	30.95%
Upper Violation Limit	45.70%
Calculated claims in violation	1,531
Lower limit transactions in violation	1,236
Upper limit transactions in violation	1,826

Note: The lower and upper error limits represent the range of potential error (e.g., if 100 samples were selected, the rate of error would fall between these limits 95 times).

It is recommended that the Plan comply with Section 3224-a(b) of the New York Insurance Law by making payment for any undisputed portion of the claim in accordance with this subsection and for notifying the policyholder, covered person or health care provider in writing within thirty days of the receipt of the claim or bill for services rendered that the claim is denied or request additional information necessary to adjudicate the claim.

B. Benefit Plan Amendment

It was noted that the Steuben Area Schools Employees' Benefit Plan Amendment "Eighth Amendment to the Steuben Area Employee' Benefit Plan" was submitted to the Department for review and approval. However, the review of Amendment 8 was closed, without approval, due to the Plan not responding to the Department's correspondence relating to such filing.

If it is the intent of the Plan to incorporate the eighth amendment to its policy benefit plan within its benefits provisions, it is recommended that the Plan re-submit such policy benefit plan form to the Department for approval.

C. Utilization Review

Section 4916(b) of the New York Insurance Law states in part:

> "(b) Each health care plan and external appeal agent shall annually, in such form as the superintendent shall require, report the number of external appeals requested by insureds and the outcomes of any such external appeals…"

A sample of Utilization Review cases were selected for review. Such sample utilization review cases were obtained from Excellus Health Plan Inc., (Excellus) the Plan's contracted utilization review agent. It was determined that one of the sampled cases went to an external appeal. The Plan failed to provide the examiner with the report which is required to be sent to the Superintendent pursuant to Section 4916(b) of the New York Insurance Law.

It is recommended that the Plan, comply with Section 4916(b) of the New York Insurance Law, by providing a report to the Superintendent of the number of external appeals requested by insureds and the outcomes of any such external appeals.

Section 4904(c) of the New York Insurance Law states in part:

> "The utilization review agent must provide written acknowledgment of the filing of the appeal to the appealing party within fifteen days of such filing…"

A review of the Utilization Review sample determined that the Plan's third party claims administrator ("Excellus") failed to provide an acknowledgment to the insured within the fifteen days of the filing of the appeal as required by Section 4904(c) of the New York Insurance Law.

It is recommended that the Plan comply with Section 4904(c) of the New York Insurance Law by ensuring that its utilization review agent, Excellus, provide a written acknowledgment letter of the filing of the appeal to the appealing party within fifteen days of such filing.

Section 4903(d) of New York Insurance Law states in part:

> "(d) A utilization review agent shall make a utilization review determination involving health care services which have been delivered within thirty days of receipt of the necessary information…"

A review of the utilization sample determined that the Plan's TPA ("Excellus") failed to make a utilization review determination for an appeal involving health care services within thirty days of receipt of the necessary information.

It is recommended that the Plan comply with Section 4903(d) of the New York Insurance Law by ensuring that its contracted utilization review agent, Excellus, makes a utilization review determination involving health care services within thirty days of receipt of the necessary information.

5. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination included fourteen (14) recommendations detailed as follows (page number refers to the prior report on examination).

ITEM		PAGE NO.
	Management and Controls	
1.	It is recommended the Plan comply with Section 4705(a)(1) of the New York Insurance Law and amend its Municipal Cooperation Agreement and its by-laws to reflect the current composition of the Plan. *The Plan has complied with this recommendation.*	9
2.	It is recommended that the Plan comply with the requirements of Section 624(a) of the New York State Business Corporation Law by maintaining minutes of all board committee meetings held. *The Plan has complied with this recommendation.*	9
3.	It is recommended that the Plan comply with Section 4705(a)(7) of the New York Insurance Law and designate an attorney-in fact to receive services of summons or other legal process in any action, suit or proceeding arising out or any contract, agreement or transaction involving the Plan. *The Plan has complied with this recommendation.*	10
	Corporate Governance	
4.	It is recommended that the Plan amend its contract with its CPA firm to include a review and rendering of an opinion of the Plan's internal control systems on an annual basis, in order to comply with the requirement of Section 4705(e)(1) of the New York Insurance Law. *The Plan has complied with this recommendation.*	11

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6. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Respectfully submitted,

_____

Charles J. McBurnie
Insurance Examiner

STATE OF NEW YORK)
) SS.
)
COUNTY OF NEW YORK)

Charles J. McBurnie, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of her knowledge and belief.

_____

Charles J. McBurnie

Subscribed and sworn to before me
This _____ day of _____2016

APPOINTMENT NO. 31279

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***BENJAMIN M. LAWSKY****, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:*

Charles McBurnie

as a proper person to examine the affairs of

Steuben Area Schools Employees' Benefit Plan

and to make a report to me in writing of the condition of said

Municipal Cooperative Health Benefit Plan

with such other information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed my name and affixed the official Seal of the Department at the City of New York

this 13th day of March, 2015

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau