Lessons Learned from Recent Data Breaches:

Strategies to Prepare for and Respond to a Breach

HIPAA Summit

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2014: The Year of the Data Breach?

Continuing through 2015?

dwt.com

Anthem

- 2nd Largest health insurance company.
- Holding company with numerous affiliates and works with independent Blue Cross & Blue Shield plans.
- Sophisticated cyber attack beginning December 2014.
- Access using high level credentials.
- More than 80 million people affected.
- 10 years' worth of consumer information.

  - Names, D/O/B, SSNs, addresses, employment and income data.
  - Not "medical information."
  - PHI.

Anthem Response

- Information disseminated (press releases, website, hotline, town hall meetings, customer reps).
- Offering identity theft protection for 2 years.
  - Automatically enrolled in protection but individual needs to sign up for monitoring (giving information).
- Notification.
  - HIPAA and state law.
  - Notice to all State AGs.
  - Notice to state consumer agencies.
  - Talking to OCR re HIPAA notification.
- Additional confusion/complications based on Anthem's role as insurance issuer and as a third party administrator for self funded health plans.

Preparation for a Breach: A Vulnerable Sector

Data Breach Incidents by Sector, 2013

Source: Norton Cybercrime Index

Industry Sector	Number of Incidents	Percentage of Incidents
Healthcare	93	36.8%
Education	32	12.6%
Government and Public Sector	22	8.7%
Retail	19	7.5%
Accounting	13	5.1%
Computer software	12	4.7%
Hospitality	10	4.0%
Insurance	9	3.6%
Financial	9	3.6%
Transportation	6	2.4%
Information technology	5	2.0%
Telecom	4	1.6%
Law enforcement	4	1.6%
Social networking	3	1.2%
Agriculture	2	0.8%
Community and non-profit	2	0.8%
Administration and human resources	2	0.8%
Military	2	0.8%
Construction	1	0.4%
Utilities and energy	1	0.4%
Computer hardware	1	0.4%

Internet Security Threat Report 2014: Volume 19, Appendix A; Symantec Corporation

10-Step Breach Response Plan Overview

1. Prepare for the possibility/eventuality of a breach.
2. Investigate.
3. Stop the harm, mitigate, and take corrective action.
4. Assess and document whether the event is a “breach” under HIPAA.
5. Analyze whether event is a breach under applicable state law.
6. Notify individuals (or the covered entity).
7. Notify HHS.
8. Notify the media and others (maybe).
9. Reassess: What can be learned from the event?
10. Wrap up and prepare for possibility of investigation/audit.

Step 1:
Prepare for the Possibility of a Breach

- Develop, implement, and document an incident response and breach notification process.
  - Test the incident response process.
- Develop/revisit Security Rule risk analysis.
- Establish an incident response team.
  - Internal Team including the point of contact.
  - External Team (attorneys, forensic experts, breach response firms, etc.)
- Consider encrypting PHI.
- Train workforce!
  - What to report.
  - Who to go to with concerns and questions.

Step 1:
Prepare for the Possibility of a Breach

- Business Associates and Subcontractors
  - ➢Due diligence on business associates.
  - ➢Know your business associates, and subcontractor/business associates; know what they do.
  - ➢Maintain a list with contact information.
  - ➢Document management system.
  - ➢When negotiating business associate contracts, consider:
    - Indemnification.
    - Addressing responsibilities in the event of breach notification.
    - Timing for reporting breach, impermissible use or disclosure, and security incident.
    - Mitigation.

Step 1:
Prepare for the Possibility of a Breach

- Consider cyber insurance
- Review any existing policies to verify:
  - Coverage.
  - Whether you can use the outside support you choose.

Step 2:
Investigate the Event

- Activate incident response and breach notification process.
  - If no process, identify individuals in the best positions to help investigate and respond to the incident.
- Identify:
  - Facts surrounding the incident: who, what, where, when, how, and why (e.g., stolen or lost laptop, backup tape, portable storage device; email or fax sent to wrong recipient; paper records thrown in the trash).
  - Type of information involved: PHI? PII? (e.g., names, addresses, PHI, SSNs, credit card numbers).
  - Number of people affected.
  - States in which affected people live and total in each state.
  - Whether the information was encrypted.
  - Whether information systems were affected.

Step 3:
Stop the Harm, Mitigate, & Take Corrective Action

- Stop the Incident!
- Preserve and secure evidence, including log files.
- Decide whether to contact law enforcement (e.g., police, FBI).
- Recovery - return systems to normal.
- Mitigate - A covered entity or business associate must mitigate, to the extent practicable, any harmful effect that is known to the entity of an impermissible use or disclosure of PHI.
  - For example, contact recipient and ask for information to be returned or destroyed.

Step 3:
Stop the Harm, Mitigate, & Take Corrective Action

- Corrective action - may need to
  - Terminate agreement with business associate.
  - Revise procedures.
  - Sanction employees.
  - Do additional training.
- Decide whether to offer:
  - Credit monitoring services.
  - Identity theft services.
  - Other support for affected individuals.

Step 4:
Assess and Document Whether Incident is a Breach under HIPAA

- Breach:
  - Acquisition, access, **use**, or **disclosure**
  - Of **PHI** (either electronic or hard copy)
  - **Not permitted by the Privacy Rule** that
  - **Compromises** the security or privacy of PHI

Step 4:
Assess and Document Whether Incident is a Breach under HIPAA

- Steps to Determine if Incident is a Breach:
  - Impermissible use or disclosure of PHI under Privacy Rule?
  - Compromises the privacy or security of PHI?
  - Excluded from the definition of a breach?
    - An unintentional use of PHI by a workforce member acting in good faith and within the scope of his or her authority, and the PHI is not further used or disclosed improperly;
    - An inadvertent disclosure of PHI by an authorized person to another authorized person, and the PHI is not further used or disclosed improperly; or
    - A disclosure of PHI to an unauthorized person where there is a good faith belief that the unauthorized person would not reasonably have been able to retain the PHI.

Step 4:
Assess and Document Whether Incident is a Breach under HIPAA

- Presumption of breach
  - Unless a *low probability of compromise* is demonstrated based on a
    - documented breach risk assessment
- Risk assessment of at least:
  - Nature of PHI (e.g., identifiability, sensitivity).
  - Unauthorized recipient (e.g., subject to confidentiality requirements).
  - Whether PHI was actually acquired or viewed.
  - The extent that risk has been mitigated.

Step 4:
Assess and Document Whether Incident is a Breach under HIPAA

- HIPAA breach notification requirement applies only to the breach of unsecured PHI.
- The breach of secure PHI is not subject to the breach notification.
- If PHI is rendered "unusable, unreadable, or indecipherable" to unauthorized individuals, it is secure.
- Technologies and methodologies that will render PHI secure:
  - Encryption.
  - Destruction.
- Safest course: Encrypt! Encrypt! Encrypt!

Step 5:
Analyze Whether Incident is a Breach under State Law

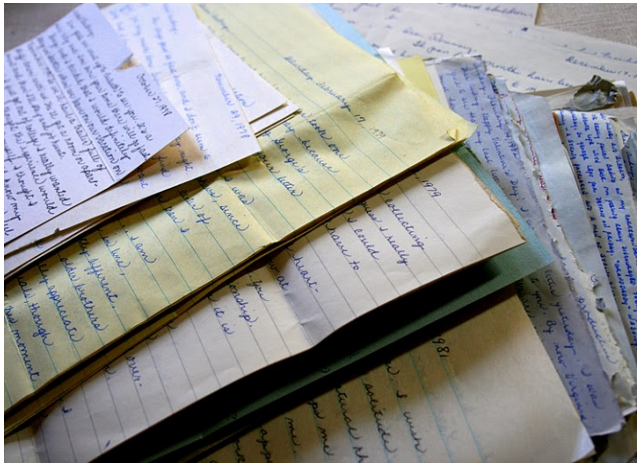
- Vast majority of states have data breach notification laws.
- Verify state law's definition of "personal information."
- Determine any exceptions to breach notification obligations (e.g., encryption, harm-based standards).
- If state breach notification law is triggered, state notification obligations may exist in addition to HIPAA.
- Most state laws allow a single notification to address both state and HIPAA requirements (beware of Massachusetts).

Step 6:
Notify Individuals

- HIPAA: Covered entity must provide notice to the individual "without **unreasonable delay**" and no later than 60 days after breach is discovered.
  - Notification should be made sooner than 60 days if possible.
  - But avoid premature notification.
  - Subject to law enforcement delay.
- Pay attention to state timing requirements.
- Discovery: When any workforce member or agent knew or should have known of the breach (excluding person committing the breach).

Step 6:
Notify Individuals

- Covered entities must notify affected individuals:
  - Via first-class mail.
  - Unless the individual has consented to email.
  - Substitute notice may be required if not able to contact people.
- Notice must include:
  - Description of facts about breach.
  - Type of PHI involved.
  - Steps individuals should take to protect themselves.
  - What the covered entity is doing to investigate the situation and prevent future breaches.
  - Contact information.



Step 6:
Or Notify the Covered Entity

- HIPAA business associates must notify covered entity of the breach **without unreasonable delay** and no later than 60 days after discovery.
- Notice to include, to the extent known:
  - Identity of affected individuals.
  - Information that covered entity must include in its notice.
- Business associate contract may address:
  - Who will make the notifications.
  - Who will pay for notifications.
  - Shorter notification time period.
  - Additional requirements for notification of breach, impermissible use or disclosure, or security incident.
- Goal: Individuals should not receive duplicative notices for the same breach.

Step 7:
Notify HHS

- Covered entities must notify HHS of the breach:
  - If more than 500 affected individuals – must notify HHS contemporaneously with notification to the individual via online notification.
  - If fewer than 500 affected individuals – must maintain a log and notify HHS no later than 60 days following the end of the calendar year in which the breach was discovered.
    - On-line notification
    - Promises the ability to enter log but for now each breach needs its own notification.

Step 8:
Notify Media and Others

- Possible Media Notification
  - ➢ If PHI of more than 500 individuals in one state is breached, covered entity must notify “prominent media outlets” in the state.
  - ➢ Different from substitute notice.
  - Check state laws to determine whether any additional notifications must be made (e.g., consumer protection agencies, Attorney General’s office, consumer reporting agencies).

Step 9:
Reassess: What Can be Learned from the Event?

- Compliance policies and procedures:
  - ➢Evaluate and revise if they do not work for the organization or do not adequately safeguard PHI.
    - For example:
    - ✓If incident involved lost or stolen backup data tape, consider changing procedure for transport and/or storage.
    - ✓If incident involved faxing information to a wrong number, consider changing procedure to require contacting the intended recipient before the fax is sent to confirm number and after the fax is sent to confirm receipt.
- Risk analysis:
  - ➢ Revisit and update, if appropriate.

Step 9:
Reassess: What Can be Learned from the Event?

- Training: Security incidents presents learning opportunities.
  - If incident was the result of employee error, consider focused retraining of particular employees and general reinforcement.
- If incident was the result of a business associate's error:
  - Verify business associate's mitigation and corrective action.
  - Consider terminating the agreement or imposing more stringent safeguards under the agreement.
- Sanction workforce, as appropriate.

Step 10
Wrap Up and Prepare for Possible Investigation or Audit

- HHS-OCR investigated every “large” breach.
- Each OCR region receives report about “smaller” breaches in its region.
- OCR trained state AGs on HIPAA enforcement.
- Investigations have been initiated via letter and by phone.
- **OCR expects cooperation**.
- Generally, OCR has been asking for:
  - Facts surrounding the breach.
  - Copies of notification letters, media notices, business associate agreements.
  - Actions taken to locate missing data, prevent further loss of data, and protect affected individuals.
  - Security Rule risk analysis.
  - Description of safeguards in place to protect the information, specifically including whether data was encrypted.
  - Compliance efforts related to policies and procedure revisions, training, and sanctions imposed.

Step 10
Wrap Up and Prepare for Possible Investigation or Audit

- Finalize documentation of incident – while it is at front of mind.
  - Breach – whether incident was a breach, including risk assessment.
  - Notification – timely and appropriate (e.g., individual, HHS, media, substitute, other required agencies).
  - Security incident report (under Security Rule).
  - Reporting under business associates contract (impermissible uses and disclosures, security incident, breach).
- Track for accounting of disclosure.
- Checklist may be helpful.

- Remember: Covered entity and business associates have burden of proof that notification was appropriate.

QUESTIONS?

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