

Payday Lending in Arkansas: Implications for Public Health

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Abstract

High-cost credit is the only option available to individuals whose incomes are too low and/or too unpredictable for them to qualify for mainstream lending sources. Check cashers who provide so-called payday loans are among the alternative lenders people with low incomes resort to when in need of a short term or emergency loan. Since 1999, Arkansas has allowed this type of loan after industry pressure led to the passage of Act 1216, which defines these transactions as “not loans” and their associated fees as “not interest.” Whatever definitions we use, payday loans are quite costly and add to the burdens low-income families already face. Whether the costs are deemed interest or fees, these loans frequently carry effective annual percentage rates of more than 400%. While seven Arkansas counties have ruled Act 1216’s fee definition unconstitutional, payday lenders continue to operate in six of these counties. Given Arkansas’ high rates of poor, uninsured, and food insecure households, the additional stress of high-cost credit obligations can only make their situations worse. Existing research shows that payday lenders target non-white populations, as well as areas with high rates of poverty and limited access to mainstream lending. The purpose of this paper is to describe the distribution of payday lenders in Arkansas’ counties in relation to rates of non-white residence, poverty, child poverty, lack of health insurance, and food stamp participation. The number of licensed check cashers in a county had a strong positive correlation with number of residents below poverty ($r=0.88$), a moderate positive correlation with a county’s percentage of urban areas ($r=0.56$), weak negative correlations with food stamp use ($r=-0.29$) and percent of uninsured residents ($r=-0.22$), and a very weak positive correlation with the percent of nonwhite residents ($r=0.08$). Our results suggest that payday lenders in Arkansas may be disproportionately located in counties with large numbers of residents experiencing poverty, and that they tend to be located in more urban counties. Research at the zip code level may help determine whether these businesses target high minority areas in Arkansas.

Introduction

Poverty, financial insecurity, and related issues have important impacts on individual and population health. Numerous studies have made the link between poverty and inequality and short- and long-term health outcomes (McDonough & Berglund, 2003; Wagstaff, 2002; Wood, 2003). Additionally, research comparing indicators of wellbeing in the United States with those of other industrialized nations has revealed the effects of negative social and economic determinants of health on nations experiencing them (Ross et al., 2005; Spencer, 2004).

Using a basic definition of poverty – “an economic state that does not allow for the provision of basic family and child needs” (Wood, 2003, p. 707) – does not tell the full story. Along with poverty comes a reduced ability to participate in many of society’s structured activities, such as obtaining primary health care, access to nutritious food, and access to credit and other financial services. Sen (1981) discussed the difficulty poor people have in establishing “entitlement relationships” that guarantee their access to food. The latest available figures show that in 2003 Arkansas had the highest levels of households experiencing food insecurity – limited or uncertain access to adequate food – in the nation, at over 15% (Hall, 2004). We can extend the entitlement concept, the idea that people earn claims to social and economic rights through, for example, successful participation in the labor market, to the ability to secure health insurance or affordable credit. Nearly 15% of Arkansas’ citizens were without health insurance in 2001 (Arkansas Center for Health Improvement, 2002).

Poverty, its correlates, and its effects are facts of life for many in the United States, and especially for Arkansas residents. In 1999, over 38% of jobs in Arkansas paid too little to enable a family of four with a full-time, year-around worker to rise above the poverty line (Economic Policy Institute, 2005). Between 2001 and 2003, median household income among Arkansans decreased, a distinction shared by only eight other states (DeNavas-Walt, Proctor, & Mills, 2004). Arkansas is

second only to Mississippi in percent of its residents living in poverty, at 18.8% (DeNavas-Walt, et al, 2004). From per-pupil spending to graduation rates, Arkansas ranks last or nearly last in the United States (Gordon, 2000) in educational achievement statistics. And these problems are even worse, in many cases, for rural residents (University of Arkansas Division of Agriculture [UADA], 2005). According to the Rural Profile of Arkansas 2005 report, only 12 of Arkansas' 75 counties are classified as urban using Census Bureau definitions, and almost half of Arkansans live in rural areas (UADA, 2005).

While it is difficult, if not impossible, to obtain data on the numbers of people resorting to various forms of high-cost credit, currently 182 check cashers offering payday loans – small, short-term loans made on the basis of current employment and a check held for future deposit – are licensed in the state of Arkansas (K. Hazelett, personal communication, May 23, 2005). This figure may underestimate the extent of the problem: in their 2004 report, Arkansans Against Abusive Payday Lending [AAAPL] noted that 24 of 72 check cashers in Pulaski County, Conway, and Fort Smith were unlicensed but remained in operation. If a similar situation holds true statewide, there may be many more than 182 of these businesses in Arkansas. For purposes of clarity, the terms licensed check casher [LCC] or payday lender will be used interchangeably throughout this paper to refer to businesses that may offer payday lending.

Lack of health insurance has an obvious relationship to health, whereas being without access to affordable financial services most of us take for granted may not suggest such a direct connection. However, being forced to use a greater portion of already limited resources for such services clearly places a lower-income person or family in the position of having even less financial capacity for other purposes, such as purchasing nutritious food and other health-promoting behaviors. Indeed, if households who use payday loans do spend substantially less on necessary health inputs or behaviors, the use of such loans could be viewed as a health disparity-producing risk factor and thus

as a disparity itself. There is a dearth of research regarding payday lending and its potential impact on individual and population health. Graves (2003) noted a lack of policymaking attention to what he referred to as economic geography. Community characteristics, including opportunities for community and individual economic advancement, are reflected in health statistics. Thus, research in this area and its translation into public health policy and practice are important avenues for health promotion professionals seeking to improve health outcomes for limited-resource individuals and communities. The purpose of this paper is to provide information regarding the distribution of LCCs in Arkansas counties in relation to county characteristics including proportion of non-white residents, rates of residents lacking access to health insurance, food stamp participation, poverty and child poverty.

Background

High-cost credit, commonly referred to as alternative financial services (AFS), is available through a variety of venues to those lacking other options. These venues include pawn shops, rent-to-own stores, “Buy-Here, Pay-Here” auto dealers (Karger, 2003, p. 93), check-cashing outlets, and payday lenders (Flannery & Samolyk, 2005). Other industry innovations include tax refund anticipation loans (RALs) (Karger, 2004); internet rebate loans that provide limited internet access and a small loan in exchange for an agreement that the borrower will “roll over” the loan every two weeks for one year (AAAPL, 2004); and phone cards with steep activation fees and contracts requiring the borrower to continue purchasing the phone cards (Fox, 2004). Due to the broad nature of the problem, although each type of high-cost credit alternative is important from a policy and health advocacy standpoint, in this paper we have chosen payday lenders as a focus.

It is clear that payday lending costs its users much more than would other types of credit. In a 2000 report, Wiles and Immergluck noted that the cost of a \$250 loan is substantially higher for patrons of payday lenders than for individuals accessing a cash advance of the same amount through

their credit cards or through a credit union. According to these authors, even for only three two-week loan periods, the cost of the \$250 payday loan is \$150 – well over half of the loan amount – while a borrower continuing to pay on the same loan over a year’s time would incur a cost of \$1000 – four times what was originally borrowed. Over that same year, these authors posit that a credit card customer borrowing via a cash advance (assuming a 5% fee and 24% interest rate) would pay only \$63 for borrowing the same \$250, while a credit union borrower (with a \$10 application fee and 16.5% interest rate) would pay only \$44.

Payday lenders argue that their interest rates do not reflect an annual percentage rate (APR) because their loans are for short-term emergencies (Stegman & Faris, 2003). However, as these authors noted, the reality is that these loans are rarely short-term, and that many customers roll over (renew the loan due to inability to pay) the debt several times, each time making their loan more profitable for the lender. In fact, in their research, Stegman and Faris found that roll-overs were “the second most important determinant of financial success. Each 1% increase in customers who borrow at least monthly generated a \$1060 increase in gross outlet revenues in 2000” (p. 24).

Highly profitable to lenders, payday loans are equally detrimental to individuals and families who resort to them. The existence of high-cost lenders, especially if it tends to justify or lessen the perceived impact of a lack of access to mainstream credit options, is a public health issue, given the potential impact of a high-cost loan obligation on a household’s ability to afford health care, nutritious food, or other needed expenditures. Exploring the location of these lenders in relation to vulnerable populations may be a first step in determining alternatives for these groups, and in effective advocacy for stricter (and enforced) regulation for this predatory industry.

Arkansas Legislative Climate and History Regarding Payday Lending

As is the case in many states, Arkansas’ legislation and legal climate regarding payday lending is in flux. Prior to 1999, no state regulation limited the activities of check cashers operating in

Arkansas, but many were sued by the Attorney General's office. In response to the suits, the industry successfully pursued legislation, Act 1216 passed in 1999, legitimizing their activities, including payday lending (AAAPL, 2004). Unfortunately for Arkansas residents, this legislation stated that these transactions are not and "shall not be deemed to be a loan" and associated fees "shall not be deemed interest" (AAAPL, 2004, p. 4), thus making them exempt from state interest caps. Further legal challenges, including rulings in several counties that the fee definition in Act 1216 is unconstitutional have occurred (National Community Reinvestment Coalition, 2003), but these businesses continue to operate seemingly without substantial interference. In fact, in all but one of the counties ruling Act 1216 unconstitutional more than one operation still exists. As in other states, check cashers who do encounter successful litigation frequently convert to the rent-a-bank or rent-a-finance-company model and continue to offer the same services (AAAPL, 2004).

Methods

Using data from the Hometown Health Factbook, Arkansas, 2002 (Arkansas Department of Health [DOH], 2004); the UADA's Rural Profile of Arkansas, 2005; and food stamp program (FSP) participation rates produced from figures provided by an Arkansas FSP manager (G. Gilkey, personal communication, June 30, 2005) we were able to distinguish counties by various factors we believed might be associated with payday lender prevalence. We obtained numbers of LCCs for each county from H.C. Klein of AAAPL (H.C. Klein, personal communication, June 1, 2005). Table 1 indicates the number of these businesses in each county, as well as total number of residents with incomes falling below 100% of the federal poverty line (FPL), percentage without insurance, percentage using FSP benefits, and percentage of nonwhite residents. The inclusion of nonwhite residents as a potentially relevant county characteristic is justified by prior research findings that payday lending operations target nonwhite communities (King et al., 2005; Oron, 2005; Woodstock Institute, 2004).

As shown in Table 1, 21 counties are listed as having no LCCs. Originally, our list included 27 counties without LCCs. Recalling AAAPL's (2004) finding that 33% of their sample were unlicensed, we presumed that the same might hold true statewide. Thus, as part of our study protocol we contacted county extension personnel in all counties for which we had no LCC listing to ask if they knew of payday lending operations in their counties. To date, 17 agents have responded. Eleven have confirmed that there is no such operation in their counties, or have stated that they know of none. Six agents have informed us of at least one payday lender currently operating in their counties.

Analyses

To determine whether a relationship exists between a county's economic stress indicators and the number of payday lenders, we used Pearson's correlation within SAS, version 9 (SAS Institute Inc. Cary, North Carolina). No assumption is made regarding a causal relationship. However, a correlation between the number of LCCs and certain county characteristics may indicate the need for further study of this issue in Arkansas.

Results

As shown in Table 1, eighteen (24%) of Arkansas counties have 20% or more of residents who lack access to health insurance. In 6 counties (8%), uninsured residents make up more than 25% of the population. The percentage of residents using FSP benefits ranged from 8.4% to 45.4%, with a mean of 20.9%.

[Insert Table 1 here]

Table 2 shows the univariate correlations between number of LCCs and selected county characteristics. The number of LCCs was strongly correlated with the total number of a county's residents with incomes below 100% of the federal poverty line ($r=0.88$), and moderately correlated with the percentage of areas in the county designated as urban ($r=0.56$); both correlations were

significant at the $p < .0001$ level. Thus, 77% of the difference in number of LCCs is explained by number of a county's residents living in poverty, and 31% is explained by the percentage of urban areas in a county. The number of LCCs was weakly negatively correlated with the percentage of residents participating in the FSP and with the percentage of uninsured residents and ($r = -0.29$ and -0.22 , respectively); however, the correlation with percentage of uninsured residents was not significant at the $p = .05$ level. Finally, the number of LCCs was very weakly correlated with a county's percent of nonwhite residents ($r = 0.07$), and with the number of African-American residents per thousand ($r = -0.01$), also not significant at the $p = .05$ level.

[Insert Table 2 here]

Discussion

The moderate correlation with percent of urban areas and strong correlation with numbers of residents whose incomes fall below 100% of the federal poverty line are understandable. Urban areas are generally population centers, and low-income people, who may not have access to other financial services, are the logical target market of businesses offering this type of loan. Our results agree with those of Burkey (2004), who found that, in North Carolina, payday lenders tend to locate in larger population centers. Likewise, lower-income groups are likely to lack access to more mainstream sources of credit.

The weak negative correlation with percentage of county residents using FSP benefits may reflect the assistance FSP benefits provide in boosting disposable income and thus lessening the need for payday loans. Alternatively, this weak negative correlation may be due to another factor, such as a variation in county FSP outreach practices. The nonsignificant correlations (between number of LCCs and percentages of uninsured and nonwhite residents) may prove to be significant if zip code level data is used in a further analysis.

There are some inherent limitations in this study. First, we were limited to using the most recent data available for each type of data in which we were interested. Hometown Health Factbook Statistics were collected in 2001, while FSP data were collected in 2002, and UADA data (regarding rural versus urban counties in Arkansas) are from 2004. However, we have no reason to think that these data have changed to the extent that our picture would be significantly distorted.

Additionally, due to time constraints, we limited our analyses to the county level. Examining the location of payday lenders in relation to zip code tabulation areas or census tracts regarding proportions of non-white residents and prevalence of economic stress indicators would provide more information.

Implications and Suggestions for Further Research

While admittedly “worst” in many attributes, Arkansas is comparable in its high poverty rates and related problems to many parts of the south. Thus, exploring Arkansas’ problems and potential solutions may inform the development of research frameworks and interventions for other southern states.

One important finding is that payday lenders are operating in counties for which the state regulatory agency has no LCC listed. Having this information may help policymakers and enforcement personnel seeking to ensure that payday lending, at the very least, takes place within the existing legal framework. This finding also may imply that Arkansas’ current payday lending legislation is not sufficient.

We anticipate that findings from this study and future research may help community health personnel and other professionals seeking to advocate for populations in need of low-cost financial services, particularly if the high costs of payday loans divert needed financial resources in families and communities. Other studies should attempt to describe the location of LCCs within Arkansas

cities and zip codes with respect to the demographic makeup and community resources of these areas.

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[food stamp participation, 2001](#)

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Table 1

Number of licensed check cashers by county and selected county characteristics

County	Number of LCCs	Percent uninsured	Number <100% FPL	Percent nonwhite	African-American residents per 1000	Percent using FSP benefits
Pulaski * **	25	11.9	46412	35.4	318	11.7
Sebastian * **	18	9.7	15558	12.8	0	16.5
Benton **	14	7.4	14281	3.9	5	8.4
Washington * **	8	15.3	19694	6.6	21	10.5
Mississippi	7	20.1	10693	35.1	329	30.2
Jefferson **	7	16.3	15642	51.9	494	27
Faulkner **	7	12.7	8731	10.5	84	12.8
Garland *	6	18.9	12861	9.5	79	15.1
Miller **	5	20.8	7390	25.4	224	23.2
Howard	5	18.4	2162	23	220	15.9
Crittenden **	4	11.6	11100	49.1	466	32.2
Union	4	34.1	7600	33.7	319	22.4
Greene	4	15.9	4866	1	3	18.6
Craighead * **	4	16	11477	9.6	78	16.2
Carroll	4	26.2	3732	1.6	1	12.2
St Francis	3	15.2	6697	50.8	3	34.7
Cross	3	17.9	3712	24.4	234	24.2
Hempstead	3	6.7	4293	31.6	298	22.7
Sharp	3	15.1	3020	1.4	52	22.4
Johnson	3	20.6	3596	2.9	13	19.8
Hot Spring	3	25.7	4145	11.2	96	17.6
Crawford **	3	16.6	7635	4.6	8	17
Pope *	3	17	7840	4.4	23	16.4
Pike	3	20.3	1575	4.7	38	14.9
Clark *	3	11.3	3451	24.1	224	14.5
Phillips	2	19.6	7409	61.7	588	45.4
Drew	2	9.9	2877	28.4	267	25.1
Randolph	2	16.1	3068	1.8	6	24
Ouachita	2	12.1	5291	40.1	385	23.4
Logan	2	9.8	3600	2.3	13	22
Polk	2	23.7	3800	2.4	1	20.8
Sevier	2	16.2	2698	7.1	62	20.2
Little River	2	18.4	2129	23.6	204	18.4
Stone	2	18	2096	1.2	1	18.1
Boone	2	15.5	5141	1.4	1	16
White	2	20.3	9216	4.9	39	14.8
Lonoke **	2	18.7	5675	7.6	66	12.3
Yell	2	10.5	3096	3.2	9	14.3
Desha	1	22	3464	48.2	462	33.1
Monroe	1	26.3	2483	39.8	396	28.4
Dallas	1	12.7	1533	42	415	24
Scott	1	24.2	2042	3.1	23	23.6
Lawrence	1	16.7	3130	1.3	5	23.2
Bradley	1	11.4	2488	28.8	288	22.8

Arkansas	1	22.9	3516	24.1	237	22.5
Nevada	1	14.1	1753	31.9	308	20.4
Independence	1	11.7	4780	3.5	22	19.1
Franklin	1	15.7	2592	2	9	18.8
Perry	1	11.6	1358	3.4	15	16.9
Cleburne	1	17.2	3499	0.9	3	14.6
Baxter	1	10.1	4755	1.2	1	13.9
Grant	1	10.1	1726	3.2	23	12.5
Saline **	1	16.4	6389	3.7	492	9.5
Clay	1	19.0	2722	1.1	1	17.2

* denotes county ruling Act 1216's fee definition unconstitutional

** denotes urban county

Counties with no LCCs: Chicot, Lee, Woodruff, Poinsett, Lafayette, Columbia, Ashley, Jackson, Newton, Conway, Fulton, Lincoln, Marion, Searcy, Van Buren, Cleveland, Izard, Madison, Prairie, Montgomery, and Calhoun.

Table 2

Correlation coefficients between number of licensed check cashers and selected county characteristics

County Characteristic	Licensed Check Cashers
Number of residents below poverty	0.88**
Percent urban	0.56**
Percent using FSP	-0.29*
Percent uninsured	-0.22
Percent nonwhite residents	0.08
Number of African-American residents per thousand	-0.01

* p=.01

** p<.0001