Drowning in Debt: A Health Impact Assessment of How Payday Loan Reforms Improve the Health of Minnesota's Most Vulnerable
March 2016

APPENDICES

Appendix A. HIA Process and Methods

HIA is a flexible process that involves six steps:

1. **Screening** involves determining whether or not an HIA is warranted and would add value to the decision-making process.
2. **Scoping** collaboratively determines which health impacts to evaluate, the methods for analysis, and the work plan for completing the assessment.
3. **Assessment** includes gathering existing conditions data and predicting future health impacts using qualitative and quantitative methods.
4. Developing **recommendations** engages partners by prioritizing evidence-based proposals to mitigate negative and elevate positive health outcomes of the proposal.
5. **Reporting** communicates findings via a written report and summaries as well as activities to disseminate findings and materials.
6. **Monitoring** evaluates the effects of an HIA on the decision and its implementation as well as on health determinants and health status.

Stakeholder Engagement

Stakeholder engagement, including participation of community members who are directly impacted by the policy, is a vital part of HIA. Stakeholders participated in the following direct ways:

Advisory Committee

We assembled a diverse group of representatives from the PICO National Network of Community Organizers, ISAIAH member congregations, payday loan borrowers, Exodus Lending, policy analysis and advocacy organizations, and the MN Department of Health. The advisory committee was responsible for ensuring the HIA process was informed by the perspectives of affected people; informing and guiding the scope, recommendations, and communications; and providing comments on the research findings. We engaged the advisory committee by having two in-person meetings and conference calls when necessary. The group contributed content and policy expertise, knowledge of resources, framing suggestions, and other guidance over an eight-month period.

Stakeholder Interviews and Focus Groups

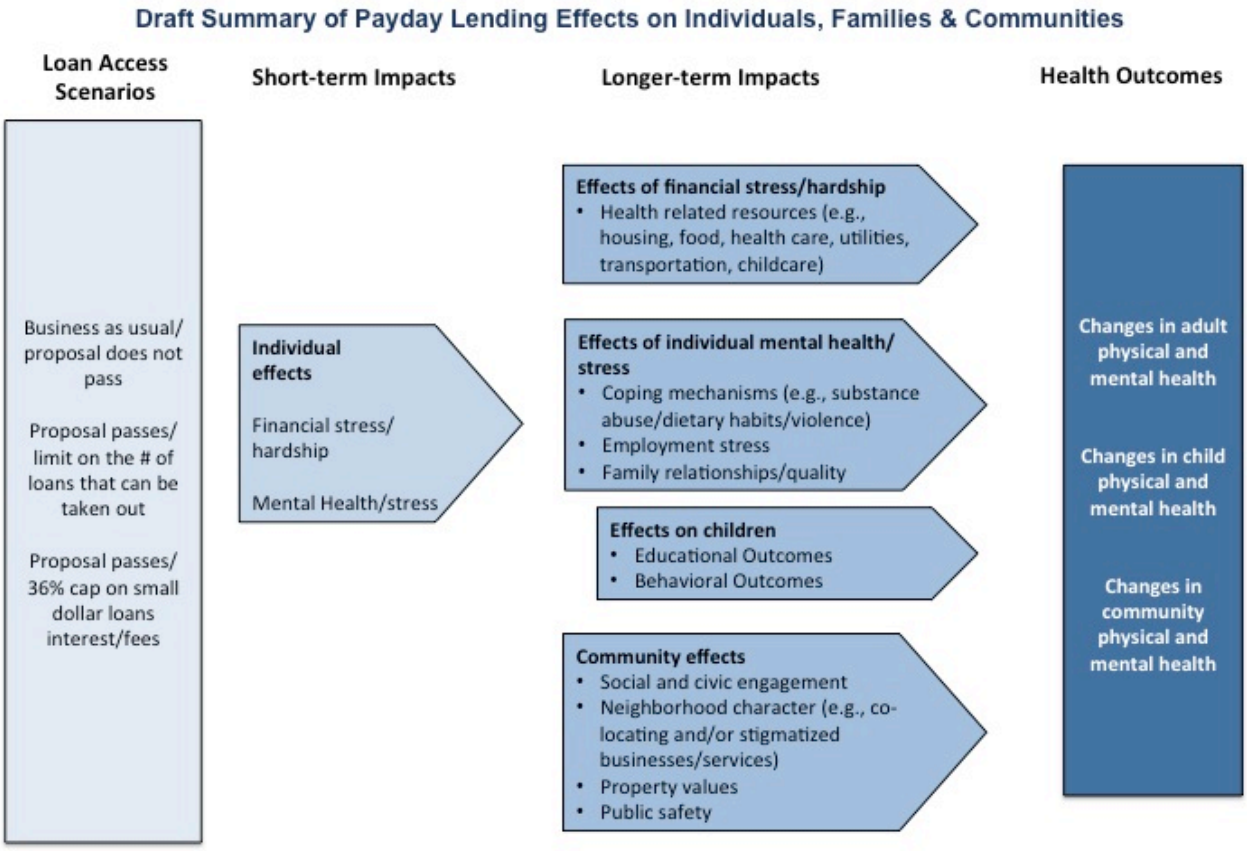
We engaged other stakeholders through key informant interviews and a focus group. These were also aspects of the assessment process and are described more below.

Below, we walk through each step of the HIA and describe our approach and process.

Scoping

Scoping for the HIA involved a preliminary review of the literature, assessment of related HIAs and health analyses, and team discussion to develop a theoretical framework for how the decision in question – reforming payday lending rules – might influence health and equity outcomes. HIP constructed pathway diagrams to represent the connections between

the decision point, the social, economic, and environmental determinants that could be impacted by that decision, and the health outcomes that could result from those determinants.



We then shared the pathway diagrams with the advisory committee during an in-depth in-person discussion, with guided discussion questions to reflect on the content, challenge assumptions, and modify, add, or delete elements as needed. The advisory committee did not change the major categories of effects proposed for assessment. Committee members suggested minor changes to emphasize or clarify impacts. We then used these pathways as theoretical guides to structure the data collection and inquiry for the remainder of the project.

Some topics that were in the pathway diagrams were not explored in the final report due to inadequate data. For example, we found minimal data to assess the relationships between payday loan stores and neighborhood resources. Similarly, we found minimal information about the connections between payday loan debt specifically and effects on children and participation in community activities. However, focus group participants did provide some perspectives on these data gaps.

Assessment

HIP used the following methods to describe existing conditions and make predictions about the impact of payday lending reforms in Minnesota on individuals, families and communities:

- *Literature review:* Performed an extensive review of the scientific (peer-reviewed) and grey (non peer-reviewed) literature
- *Quantitative data:*
    - Analysis of the U.S. Census' American Community Survey data for Minnesota.
    - Gathered summary statistics from administrative agencies (e.g., MN Department of Health) and third party data aggregators (e.g, County Health Rankings)
    - Analysis of data provided to HIP by the Minnesota Department of Commerce on payday lending storefront locations and type of lenders.
- *Qualitative data:*
    - Conducted stakeholder interviews with financial and social services providers, borrowers, state and national advocacy organizations, policy analysts and researchers, financial services experts, and policy makers;
    - Conducted a focus group with adult Minnesotans who had either taken out a payday loan or had direct experience with a friend or relative who had; and

Stakeholder Interviews. Interviewees provided valuable information about the experience of payday loan debt, technical and financial background, research advice, information about the broader historical and political context of payday loan policies, and other perspectives that were useful for the HIA findings and recommendations. Interviewees were identified by ISAIAH, advisory committee members, journal articles and reports referenced for the literature review, and by interviewees themselves. We requested interviews via email and we gave interviewees the option to see interview questions ahead of time. HIP conducted a total of fourteen interviews, each of which was over the phone and between 45-60 minutes. We developed different interview guides for interviewees depending on their areas of expertise, and interviewees granted permission to use interview data as a source for this HIA. HIP synthesized interview notes according to the themes of the report and incorporated to support existing conditions findings.

Several stakeholders, including the State's Department of Commerce, the Federal Reserve Bank of Minnesota, and the state Attorney General's office provided resources and materials related to payday lending, but would not go on record for a formal expert interview for this report. ACE Cash Express did not return phone calls for the report. As a result, these stakeholders' perspectives are not directly reflected in the assessment.

Focus Groups. HIP conducted one focus group to answer questions where there were gaps in the existing conditions, to confirm findings from these sources, and to provide additional localized context and understanding of individuals' experiences. An advisory committee member helped to organize the focus group with borrowers by posting flyers around the organization and community with which the advisory committee member was affiliated. Participants were served dinner, compensated for their time, and offered accommodations for transportation or childcare if needed.

The focus group took place in Minnesota and two staff from Human Impact Partners facilitated the groups and switched off leading the discussion and taking notes. Participants provided verbal consent to participate after receiving a detailed description of what would occur, how it would be recorded and how their stories would be used. We allotted one and a half hours for the discussion, which was based on a set of questions to

facilitate discussion about individual financial and health, family, and community effects of payday loans. We took detailed notes, which in addition to audio recordings, were used to clarify specific quotes as needed. All participants were sent the final quotes that were used in the report in advance, with an opportunity to have them deleted or modified if they felt the quotes did not accurately reflect what they said.

Human Impact Partners staff reviewed the focus group notes to identify discussions that could be coded according to the themes and categories of the findings. Finally, data were analyzed by reviewing all codes to derive and further summarize the discussion points that most clearly represented the overall concepts. Selected examples of these codes were incorporated into the final HIA report where they offered additional context, depth, validity, or original concepts.

Strengths and Limitations

We faced several limitations in conducting this assessment. For example, much of the research relevant to the health effects of payday loans addresses the broader effects of economic insecurity or debt, but not specifically the experience of having payday loan debt. In this context, we used research on the effects of debt as a proxy for payday loan debt, recognizing that the experience of payday loan debt is a unique and extreme form of debt. And while we collected qualitative data to describe the experience of payday borrowers in their own voices, these findings are not meant to compare borrowers with non-borrowers to make claims about statistically significant differences. Finally, with any study of how a change in policy affects outcomes, there are many economic and social changes in the lives of financially strained people that also impact the outcomes of interest studied in this report.

There are also numerous strengths. The participation of advisory committee members ensured we considered the range of potential impacts that could result from policy changes, and they also connected us with the community of researchers and analysts examining these issues. As a result, the scope of the assessment and evidence examined is thorough. Furthermore, their connections to borrowers and the experience of being in payday loan debt provided us with access to meaningful and credible stories that both illuminate and support our findings.

Appendix B: Our Perspective on Health and Key definitions

Our Perspective on Health

While health is influenced by our genes and the personal choices we make, over 50% of our health and well-being is determined by social and environmental conditions, such as where we live, whether we have a job, and larger social and political forces like racism and sexism.[94,95] The public health community calls these the social determinants of health, or the circumstances in which people are born, grow up, live, learn, work, and age and the systems in place to deal with illness. These circumstances are shaped by a wider set of economic and social policies, and there are many opportunities for such policies to promote health and build healthy communities.[96] Payday lending reforms represent an opportunity to impact the social determinants of health and health inequities.

Many of the pathways through which the effects of income, poverty, and wealth are seen highlight the importance of mental health. Therefore it is important to be explicit about its treatment in this research. According to The World Health Organization, "Mental health is an integral part of health, mental health is more than the absence of mental illness, and mental health is intimately connected with physical health and behavior (pg. 2)."[97]

Mental health is increasingly seen as integral to overall health and well being and the evidence highlights the relationship between mental and physical health and their importance for educational achievement, work success, social relationships, reduced crime, and preventing harms associated with substance use. Therefore influencing mental health through a focus on the social determinants of health could result in, not only, improved physical health, but also educational performance, work productivity, family and community relationships, and safety.

Psychological factors, including stress and its mental health correlates like depression and anxiety are thought to be key mechanisms through which socioeconomic status 'gets under the skin' to impact health and health disparities.[73]

Definition of Health Disparity and Health Inequity

Disparity is defined as a noticeable difference, or a lack of similarity. A *Health Disparity* is a difference in health status across population groups, which can sometimes be expected (e.g., cancer rates in elders vs. children).

Inequity refers to an injustice or a lack of fairness in the circumstances of one population group compared to another (e.g., inequity in wages paid to women vs. men). A *Health Inequity* is a difference in health outcomes across population groups that is the result of socially-determined, systemic, avoidable, unfair, and unjust circumstances (e.g., breast cancer death rates between African-American and white women).

Appendix C. County Health Rankings Complete Table and Definitions

The following table expands on table 4 in the HIA report by providing data on all of Minnesota's counties.

Appendix Table 1. County Health Rankings Data for Minnesota

	Payday Storefronts		County Ranking	Health Outcomes			
County	2015 Number of Storefronts	2015 Number of ILT Storefronts	Health Outcome Rank	Years of Potential Life Lost Rate*	% Fair/ Poor Health†	# Physically Unhealthy Days‡	# Mentally Unhealthy Days§
State Overall	**72**	**42**	**NA**	**5038**	**11**	**2.8**	**2.6**
Aitkin	0	0	69	5984	17	3.0	3.3
Anoka	7	5	48	4915	12	3.1	2.9
Becker	1	0	67	7231	10	2.8	2.1
Beltrami	1	0	83	8380	11	2.7	3.1
Benton	0	0	58	5596	12	3.3	2.5
Big Stone	0	0	44	6022		3.3	
Blue Earth	1	1	28	5009	11	2.1	2.3
Brown	0	0	11	4920	10	2.5	2.0
Carlton	2	0	66	6179	10	3.6	3.9
Carver	0	0	1	3449	8	2.7	3.0
Cass	0	0	86	8133	13	3.2	3.6
Chippewa	0	0	73	6619	17	2.5	
Chisago	0	0	45	4812	13	3.0	2.9
Clay	2	0	57	5563	11	3.2	2.8
Clearwater	0	0	78	7760	9	3.6	2.5
Cook	0	0	33	5085	10	3.2	2.3
Cottonwood	0	0	71	5969	22	4.4	1.2
Crow Wing	1	0	59	5393	16	3.5	3.9

Dakota	5	3	19	4319	10	2.7	2.5
Dodge	0	0	14	4871		1.8	2.2
Douglas	2	0	32	5097	11	2.5	2.0
Faribault	0	0	56	5410	10	4.2	
Fillmore	0	0	4	4519	9	2.6	1.6
Freeborn	0	0	64	5393	14	3.6	3.9
Goodhue	0	0	17	4776	9	2.1	2.7
Grant	0	0	60	6417			
Hennepin	22	20	46	4946	9	2.7	2.5
Houston	0	0	21	4539	10	2.4	2.8
Hubbard	1	0	47	5597	13	2.8	2.7
Isanti	0	0	49	4766	13	3.7	3.5
Itasca	1	0	68	6445	14	2.5	2.1
Jackson	0	0	70	6200	6	2.8	2.3
Kanabec	0	0	51	5640	14	3.0	4.0
Kandiyohi	1	0	23	5002	10	3.1	1.9
Kittson	0	0	42	5664			
Koochiching	0	0	72	6424	12	3.9	3.5
Lac qui Parle	0	0	50	7358		2.1	
Lake	0	0	79	5985	20	3.6	2.0
Lake of the Woods	0	0	16	4883			
Le Sueur	0	0	9	4243	13	3.3	1.7
Lincoln	0	0	27	5481		2.0	
Lyon	0	0	35	5147	12	1.6	2.6
Mahnomen	0	0	87	10910		2.3	5.7
Marshall	0	0	30	4570	11	1.7	
Martin	0	0	41	5499	11	1.5	2.3
McLeod	0	0	5	4549	8	2.1	2.3
Meeker	0	0	36	5686	10	2.2	1.9
Mille Lacs	0	0	82	7804	13	3.5	2.7
Morrison	1	0	77	6398	17	3.7	3.9

Mower	0	0	43	4758	12	2.9	3.7
Murray	0	0	75	6985		4.1	
Nicollet	0	0	18	4924	8	2.4	1.9
Nobles	0	0	3	4189		2.4	1.2
Norman	0	0	84	7242	12		
Olmsted	2	1	15	4569	6	2.3	2.1
Otter Tail	3	0	54	5559	12	3.2	3.3
Pennington	0	0	61	6045		2.8	2.5
Pine	0	0	80	7395	13	3.3	3.3
Pipestone	0	0	52	5814			
Polk	0	0	76	7570	11	2.7	2.4
Pope	0	0	65	6395	9	2.5	2.6
Ramsey	10	8	63	5621	11	2.8	2.6
Red Lake	0	0	40	6547		1.2	
Redwood	0	0	6	4925	7	1.3	1.8
Renville	0	0	85	8183	18		
Rice	0	0	29	4376	11	2.4	2.9
Rock	0	0	38	5223			
Roseau	0	0	34	5200	9	3.5	
Scott	0	0	8	3769	9	2.6	2.5
Sherburne	0	0	39	4685	14	2.9	2.7
Sibley	0	0	37	5318		2.7	
St. Louis	4	1	74	6460	13	3.2	3.3
Stearns	4	2	31	4711	10	2.5	2.2
Steele	0	0	12	4675	7		2.2
Stevens	0	0	24	4860	19	3.2	3.5
Swift	0	0	20	4991			
Todd	0	0	55	5757	13	4.4	2.2
Traverse	0	0	62	7019			
Wabasha	0	0	25	4772	9	2.7	3.5
Wadena	0	0	81	6334	14	4.0	5.1
Waseca	0	0	13	4359	11	2.2	

Washington	1	1	7	3915	9	2.9	2.2
Watonwan	0	0	26	5931	8	1.9	
Wilkin	0	0	2	3645		3.3	
Winona	0	0	22	4723	9	2.4	2.9
Wright	0	0	10	4248	9	2.8	2.1
Yellow Medicine	0	0	53	5178		3.8	4.4
Source: 2015 County Health Rankings (available at: http://www.countyhealthrankings.org/). The County Health Rankings is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute and are compiled using county-level measures from a variety of national and state data sources. These measures are standardized and combined using scientifically-informed weights. Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, e.g. 1 or 2, are considered to be the "healthiest." Counties are ranked relative to the health of other counties in the same state.							
Definition:							
* Years of potential life lost before age 75 per 100,000 population (age-adjusted), National Center for Health Statistics - Mortality files, 2010-2012							
† Percentage of adults reporting fair or poor health (age-adjusted)							
‡ Average number of physically unhealthy days reported in past 30 days (age-adjusted), Behavioral Risk Factor Surveillance System, 2006-2012							
§ Average number of mentally unhealthy days reported in past 30 days (age-adjusted), Behavioral Risk Factor Surveillance System, 2006-2012							

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