Walden University

College of Social and Behavioral Sciences

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2013

Abstract

The Impact of Health Care Benefits on Employee Job Satisfaction

by

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MPA, The University of Akron, 1996

BS, The University of Akron, 1994

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Policy and Administration

Walden University

August 2013

Abstract

Business profitability is the product of many things, including good management, a quality product or service, and a stable workforce. The latter 2 elements are dependent on minimal employee turnover, as experienced employees lead to consistency and skill in dealing with the public and producing quality services and manufactured goods. What has not been shown is whether health care benefits contribute substantially to employee satisfaction, a factor the literature suggests is important to minimize employee turnover. The purpose of this study was to determine whether a correlation exists between employee satisfaction with health care benefits (SWHCB) and overall job satisfaction (JS). The theoretical frameworks were Maslow's hierarchical self-actualization through job satisfaction related to having health care benefits and Bandura's motivation factors that lead to satisfaction. Data were collected for both the Jobs in General questionnaire that measures job satisfaction and a researcher-designed survey that measured health care benefits satisfaction. The sample population comprised 150 anonymous volunteers who were part of an online university participant pool and an Academy of Management group who completed the surveys using web-based SurveyMonkey. Multi-linear regression showed that variables of age, gender, and job title were not correlated with SWHCB and JS. The data did suggest, however, a moderately strong positive correlation between SWHCB and JS. The implications for social change include informing organizations and policy makers that the correlation of employee SWHCB to JS may necessitate company cost-benefit examinations. These examinations could result in improved HCB and increased employee satisfaction, leading, in turn, to reduced job turnover and increased workforce stability.

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Dedication

I dedicate this dissertation to my daughters, who know too well the long hours, frustrated weeks, and exciting moments I experienced. My husband receives a special dedication, as he understands the level of commitment needed to achieve a professional degree and fulfill a dream. I also dedicate this work to my parents, who know the numerous battles I undertook to get to this point. A word of appreciation also goes to those patient and supportive people who accompanied me on this journey.

Acknowledgments

I want to thank the e-Learner Working Mothers Scholarship Program. The financial relief made the degree more easily attainable. Considerable credit also goes to Dr. Elizabeth C. Wilson, who served as both as a mentor and chair throughout my program. I also want to thank my committee member, Dr. Paul Rutledge, for carrying out the methodological commitment under pressing deadlines and Dr. Mark Stallo for endorsing a topic based on my longstanding passion, interest, and drive. I also want to thank academic advising, course work professors, and the IRB.

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Chapter 1: Introduction to the Study

A depressed economy can affect many aspects of people's lives. The concomitant loss of business revenue may force companies to reduce not only salaries but also employee benefits, which may reduce employees' perceptions of the value and appeal of the job. Although not typically thought of as critical to young employees when a job is offered, health insurance, retirement benefits, and vacation plans typically serve as incentives to accepting a job. These perquisites can also ease the pressures of workplace stressors when employees know that the times in their lives that can be most costly—illness and the retirement years—are lesser concerns than they might be if they lacked these benefits.

Different factors contribute to job satisfaction (JS): working conditions, perceived respect from employers and fellow workers, salary, vacation, retirement, investment opportunities, and other elements (Abraham & Grant, 2008). Any of these factors can motivate an employee to stay with a company, but because the cost of medical care and procedures has become too expensive for many people to pay for themselves, having medical care benefits may outweigh other considerations (Yamamoto, 2011).

In 2009, "two-thirds of adults residing in the United States had been told by a health care provider that they had one or more chronic conditions" (American Psychological Association, 2009, p. 9). The chronic illnesses Americans face include "asthma, diabetes, heart disease, high blood pressure, [and] cancer" (Fox & Purcell, 2010, p. 7). The costs associated with health care benefit packages have risen, and organizations continue to debate the best formula to balance organizational and employee costs. This

goal is ideal yet practical for organizations. In the meantime, employees with choices of benefits packages with varying company and employee contributions struggle to interpret various adjustments to determine how policies affect them directly and indirectly.

The contribution of health care benefits to employee JS can be relevant not only in hiring, but also in an employee's decision to stay with a company (Deery, 2008). As organizations experience a shift in interests, expectations, and ultimately revenue management, so does the need to understand employee motivators. My purpose in this study was to determine the variables that affect the kinds of satisfaction that motivate employees to contribute to and remain with a company. Uncertainty, of knowing key contributing motivating variables, may create frustrated employees, a situation that may, in turn, negatively affect communication and levels of productivity (Avey, Hughes, Norman, & Luthans, 2008; Holden et al., 2011).

The frustration of poor communication and low work productivity levels is an indicator to pay attention to a specific department need or lack of motivation. This frustration may also contribute to reduced JS. Dencker, Joshi, and Martocchio (2007/2008) observed that employee benefit systems are designed and implemented based on the assumption employees share similar perspectives on benefit systems. To simplify the process of designing and delivering benefits, organizations and insurance companies follow different interpretations and offer a variety of programs. Benefit systems carry out the aspects of benefit systems comprised of organizations or entities that manage and provide treatment and preventive services for the healthy, not well, and injured. The system, according to Taber (2009), is defined as the physicians and their

assistants, dentists and their assistants, nurses and their surrogates. Also included in defining health system medical care benefits are the various levels of diagnostic and care facilities, voluntary organizations, medical administrators in hospitals and government agencies, the medical insurance industry, and the pharmaceutical and medical device manufacturers.

Background of the Study

Health benefits may be called *health insurance*, *medical coverage*, or other names, and the benefits that are available may cover, in varying degrees, the costs of a variety of services that "promote sound physical and mental health, including physical examinations, diagnostic testing, surgery, hospitalization, psychotherapy, dental treatments, and corrective prescription lenses for vision deficiencies" (Martocchio, 2011, p. 136). Organizations that provide this coverage may engage in a contractual agreement with health care provider networks or insurance entities to promote an economical combination of services for employee needs. The overwhelming cost incurred by individuals without adequate insurance or an economically devised health plan can bankrupt an individual or family (Schoen et al., 2010).

Companies may struggle to offer the kinds of benefits and perks employees desire without spending more on the offerings than is practical, and if employees are not well-informed about the options before them, spending appropriately can be difficult. For organization leaders to understand and meet the health care benefit needs of employees, human resource departments as well as senior management must be familiar with the specific needs of employees. If the work force is comprised of workers whose ages range

across the spectrum, who have wide differences in years of experience, and who have salaries that vary greatly, the task of creating options for benefits can be complex (Martocchio, 2011).

The differences in needs caused by differences in employee ages alone suggest potential for intergenerational conflict within the workplace over the benefits a company offers, particularly if employees sit on committees that develop the packages that are offered. Young people may need maternity leave for both the mother and the father (Bowes, 2009; Coltrane, 2009), but the opportunity to begin to pay for long-term care when the premiums are low would be less likely to appeal to young people and appeal to those in middle years. The ages of employees may have more effect on health benefits than any other element (Lahey, 2007), and when an organization finds the ages of its workers has shifted, it may have to adjust its health care benefit offerings.

Problem Statement

Many organizations struggle to find a balance between maintaining a productive and satisfied work force while offering workers the kinds of benefits they desire. This lack of connection or understanding of the needs of employees can contribute to larger communication issues. The problem is that it is not known if employee JS is correlated with satisfaction with an employer-provided health care plan. Without this information, organizational leaders may not have all the information they need to maximize employee satisfaction and the concomitant positive employee outcomes such as lower turnover, higher morale, and better job productivity.

Purpose of the Study

The purpose of the study is to determine if there is a correlation between the level of satisfaction with employer-provided health care benefits and the JS of employees. In the study, I determined if health care benefits of employees with a high score on the health care benefits survey tended to have better JS, according to the two instruments combined to assess this level of association. A positive correlation was found between satisfaction with health care benefits (SWHCB) and JS, allowing organizational leaders to consider modifying their health care benefits improving employee JS, a factor that can result in better employee outcomes. In better understanding the association between health care benefit plans or packages as they relate to the level of job employee JS, organization leaders may improve organizational relations.

The goal is to strive for a practical and informed health policy management decision in organizations. Responses from other studies dealing with health care benefits did not explore the level of interest but merely ranked various factors contributing to overall employee benefits and JS (News Briefs, 2007). Factors contributing to employee JS was comprehensively explored by Victor (2010) along with the Society of Human Resource Management from 2002 to 2009. JS, benefits as a whole, and compensation were rated in order of importance as key contributors to employees' JS.

The survey questions were designed to measure the perspectives of employees in for-profit organizations, isolating the level of SWHCB and determining the connection between JS and health care benefits. Both employers and employees stand to benefit from

more informed leadership that understands the relevance and contributions of health care benefits to JS.

Nature of the Study

This quantitative study investigated the relationship between satisfaction with health care benefits and job satisfaction. In this study, I conducted a dimensional analysis using a set of variables to better understand the measurable influence of SWHCB on an employee's JS. The population was employees over age 18 in for-profit organizations that provide medical benefits. The participants were members of the Walden University participant pool.

Research Questions and Hypotheses

Research Question 1: Is there a correlation between JS and the level of SWHCB?

H_{10}: There is no correlation between JS and SWHCB.

H_{1a}: There is a correlation between JS and SWHCB.

Research Question 2: Does age moderate the relationship between JS and the level of SWHCB?

H_{20}: Age does not moderate the relationship between JS and the level of SWHCB.

H_{2a}: Age moderates the relationship between JS and the level of SWHCB.

Research Question 3: Does gender moderate the relationship between JS and the level of SWHCB?

H_{30}: Gender does not moderate the relationship between JS and the level of SWHCB.

H_{3a}: Gender moderates the relationship between JS and the level of SWHCB.

Research Question 4: Does job title moderate the relationship between JS and the level of SWHCB?

H_{40}: Job title does not moderate the relationship between JS and the level of SWHCB.

H_{4a}: Job title moderates the relationship between JS and the level of SWHCB

Research Question 5: How do age, gender, job title, and satisfaction with one's health care benefits collectively predict JS?

H_{50}: Two or more of the independent variables of *age*, *gender*, *job title*, and *health care benefits* do not better predict JS than any single independent variable alone.

H_{5a}: Two or more of the independent variables of *age*, *gender*, *job title*, and *health care benefits* better predict JS than any single independent variable alone.

Theoretical Base

In this quantitative study, I measured levels of satisfaction among employees receiving health care benefits in the work place and the level of satisfaction in the measured perspectives of employees in the work place (see Appendix A). I also addressed a point made by Dencker, Joshi, and Martocchio (2007) that questions the assumptions organizational leaders have about employees when making larger decisions that affect their lives. The point I primarily targeted was the effect health care benefits have on individual JS. Rad and De Moraes (2009) also considered the level of satisfaction of those working in health care to include the contribution technology can make to simplify more challenging work place tasks. This simplification, in turn, is

viewed as a method of improving the quality of work experience, communication, and education of employees about health care benefit changes.

Using a meta-analysis to show levels of correlation compensation and employee satisfaction is common in the social sciences, although theorists' perspectives and strategies used to determine correlations or association between satisfaction and employee benefits vary. Investigations into the correlation between health care benefits and JS or motivation have been only a small part of much larger studies, and there are limited reviews on the topic. The changes experienced and expected in the future as a result of the Patient Protection and Affordable Care Act (PPACA) may alter the way organizations provide health care benefits. The ruling on the PPACA made by the Supreme Court in June 2012 affects medical care in the United States on many levels. Sacks (2012) wrote, "The mandate requires that virtually every American, starting in 2014, have health insurance or pay a tax penalty" (p.1).

Definitions of Terms

Employee benefits: Benefits given to an employee in addition to monetary compensation. Typically, they are comprised of things such as sick leave, health care insurance, and vacation time.

Job satisfaction: when employees like (are satisfied) or dislike (are dissatisfied with) their jobs. Satisfaction in this study was measured on a five point Likert scale from most dissatisfied to very dissatisfied.

Universal health care: Universal health care, also known as national health insurance (NHI), is defined as "health care for all residents of the United States funded by

the federal government under its single-payer system" (Cummings, 2004, p. 1). The United States remains the only industrialized nation without government-sponsored single-payer health care" (p. 1).

Assumptions

Organizations make decisions about health care benefits for employees based on many things such as cost, population, and kind of business, factoring in the purpose of the health care benefits. In addition, the way the stipulations of the PPACA and its provisions are implemented may change other considerations. PPACA may change the overall cost structure of health care, methods of delivering medical care, increased need for medical providers, wait time for specialized provider care, and quality of care. In trying to conserve costs, many organizations may offer limited benefit plans, shift more of the cost to employees, or offer only those options required by law (Domaszewicz, Havlin, & Connelly, 2010).

I assumed participants provided honest responses when completing research survey in order to carry out this study.

Limitations

Limitations of the study included considering the views of those only in the private sector. The views of employees in this sector may significantly vary compared to those in the public sector and those receiving Medicare, Medicaid, and a general health care benefit plan as sole proprietors and small business owners. Survey respondents included those in the Walden University participant pool, and there may be too few who

have had experience with employer benefits, may be self-employed, or are in some other way unfamiliar with the concepts or practices.

Delimitations

Delimitations included questioning people who are in the private sector so as to create commonality among respondents and the general health care benefits received. I designed a specific survey to question the level of SWHCB and used an already existing study to determine the characteristics of a satisfied work environment. In combination, the two surveys determined how health care benefits impact the overall perspective of JS.

Significance of the Study

The significance of the study is that it may add perspective to the design, use, and overall understanding of health care benefits. By using a survey designed to assess the level of satisfaction with employer-provided health care benefits and determining whether level of satisfaction is correlated with the level of employee JS, organizational leaders may realize new ways to optimize their health care plans in an effort to improve employee JS and concomitant positive employee satisfaction. As there is no available study of the connection between JS and health care benefits, the results may clarify how employees feel about this benefit. Activities done within the workplace to promote a better lifestyle can also speak to the importance and use of an employee's health care benefits.

Those without coverage or an alternate health care plan may qualify for emergency room treatment, and many hospitals are required to treat individuals who come to the emergency room even if the person lacks insurance. The concern is cost of

health care insurance, administration of care, implementation influence a rise to both employees and employers.

The transfer of more health care costs to employees will have broad ramifications, further justifying the need to understand the connection between health care benefits and the initiatives organizations take through such things as wellness programs to improve JS as a larger solution. The logical path in using a wellness program as a preventative measure to offset hospital cost may be a viable option. A more complete understanding of the connection between employees and the health care benefits they are receiving can clarify the level of pleased employees in a work place.

Summary and Transition

In Chapter 1, I presented the background of the study and its importance in today's economy and workplace. The chapter included the importance of the study, the background of the issue of employee health benefits, and the conflicting needs of different employees. I conducted a comprehensive investigation into employee SWHCB using participants from the Walden University participant pool, which met the minimum 150 participants required to provide statistically significant results that generalized a larger population, as it is composed of a broad range of professionals from various backgrounds, experiences, and geographical locations. The social change that may accrue from the study includes the possibilities that companies will better understand employee health care needs, will design health care coverage in ways that give employees more options for coverage, and better balance employee and company contributions to their coverage.

In Chapter 2, I will present a review of the available literature on employee satisfaction with their health care coverage and options. I will also review the available research options for their suitability. Chapter 3, will be the research methodology. Chapter 4 includes a quantitative analysis of the methodological approach used to present results. Finally, I state the findings of the results in Chapter 5 and make appropriate recommendations according to the literature, methodological study, analysis, and implications identified.

Chapter 2: Literature Review

The literature review will present available studies of (a) individual perspectives of health care benefits, (b) how those perspectives affect JS, (c) how JS is determined based on historical data and current experiences, and (d) the JS of employees based on changes in health care benefits. Databases available from the Walden University Library provided access to many articles on workplace satisfaction. These databases included Academic Search Complete/Premier, EBSCO, Behavioral Studies and Psychology, Google Scholar, Health Sciences and Nursing, Management and Business, and Public Policy and Administration. Several sources overlapped and were available through the Walden University Thoreau database. I compare various studies throughout the body of the literature review. The majority of studies and empirical data in quantitative studies are used to best assess the value placed on levels of satisfaction across industries, organizations, and time periods.

When an employee is not on the job, the costs to business are significant. Stewart, Ricci, Chee, and Morganstein (2003) noted, “Productivity losses related to personal and family health problems cost U.S. employers $1,685 per employee a year, or $225.8 billion annually” (p. 1240). Despite limited data specifying the direct impact of health care benefits to JS, legislation affects the day-to-day lives of individuals. Because there have been limited studies of the effects of health care benefits on employee decisions and the quality of interactions between the employer and employee about those benefits, further investigation into those relationships is warranted.

Dencker, Joshi, and Martocchio (2007) investigated the shift in interests and motivation of employees. The results showed "heterogeneity of age" (p. 210), meaning that the needs and desires of employees whose age differences were wide ranging made a comprehensive plan that fits everyone impracticable to institute. Dencker et al. also studied 20th century demographic trends and population projections for the 21st century. The data from the research suggested that many employers no longer seek to fulfill the interests and needs of employees. As the larger population in the workforce shifts in age and interests, employers will need to identify the particulars of the various age groups, and factoring in those differences will require greater initiative to determine motivators related to medical benefits. This point suggests that the differences in respective health care benefit needs will affect the design of the benefits that are offered and their operational costs down the line.

The concern about the cost of benefits becomes more central as the cost of the health care mandates on employers potentially reduce other benefits, programs, and compensation. The best health care benefit for employees is also driven by generational needs. An older workforce will not have the same health care concerns as younger workers, meaning the design of health care policies and packages are more challenging to create and vary according to age group. The consequence can mean a struggle for organizational leaders to manage the heightened cost of providing care for the majority of employees.

Shafiro, Hanson, Truxillo, and Hammer (2007) and Williams, McDaniel, and Ford (2007) discussed the implications and impact of compensation and employee

benefits as an issue identified from the 1960s and not fully understood by organizational leaders. At times, according to Shafiro et al. (2007), leaders may make decisions based on inaccurate data, outdated material, and misunderstandings of the impact of changed benefits such as child care, retirement, and health care on employees. Long-term implications cited in the study included employee decisions to stay in a position rather than accept a better-paying job with fewer benefits, a factor that can compromise plans and confound expectations.

Dencker et al. (2007) challenged the organizational assumption that employees throughout the workforce are similarly motivated to perform when they have the same benefits; however, based on the results of their research, motivators vary depending on the age spectrum. Contributors to employees' SWHCB will vary according to gender, age, health history, and other indicators. Employers cannot make any assumptions about factors such as age, gender, or any other demographic of an employee and family members may also benefit from an employee's health care benefit package.

Rad and De Moraes (2009) reviewed the factors contributing to employees' JS and dissatisfaction in the health care industry. Initially, the study confirmed how the need for qualified individuals to be in a position contributed to satisfaction. Key contributing variables needed to determine levels of motivation and satisfaction included attitudes toward rapidly changing and advancing technology in the health care industry, demand for quality patient care, and commitment to the position and the organization. Concerns about employee JS are just as important as, if not more important than, those in knowledge-based sectors such as the health care industry and related business sectors,

particularly in professional service-based organizations such as hospitals, where long-term specialist training and retention issues are highly important (Rad & De Moraes, 2009, p. 51).

Rad and De Moraes (2009) found men on average were older and had more years experience than female employees across the health care organizations surveyed. Men showed an average of 12.8 years of experience, while women averaged 9.3 years with a combined an overall score of 3.26 (moderately satisfied) in a 5-point Likert-type scale for levels of JS. Their findings showed that benefits, rewards, wages, communication, promotions, and working conditions showed the lowest levels of satisfaction (p. 55). However, the areas found to show improved levels of motivation included such things as loyalty to employees, good working conditions, and discipline. Employee benefits and health care benefits were not listed as items that affected motivation. The question of how knowledgeable employees are about their health care benefits may also affect how satisfied they report they are.

Williams, McDaniel, and Ford (2007) provided meta-analyses of varying dimensions of compensation to determine their role and impact on employee satisfaction. The components of their study included “pay level, pay raises, benefit levels, pay structures, and administration satisfaction” (p. 429). As current organization leaders and employees have a strong grasp of the role health care benefits play and the influence on life practices, adjustments in decisions and planning continue to be needed. In establishing the most suitable method of investigation and designing the methodology, the researchers determined “separate models and theories concerning the antecedents and

consequences of the different compensation satisfaction dimensions will be needed to guide further research and practice" (p. 430).

In determining an employee's level of satisfaction, it must be made clear that it is not compensation as a whole that is the concern but the dealing with the costs of medical care--a multidimensional assessment. The goal continues to be determining how employees perceive the use of health care benefits and whether it affects how motivated and satisfied they are as employees.

Organizations may recognize the high cost of health care benefits but realize they can more likely meet organizational goals with satisfied employees and, as a result, be more willing to invest in costlier programs. Poornima (2009) analyzed the efforts of human resource departments to meet levels of employee satisfaction to determine the factors that contributed to that satisfaction. Poornima reported the findings of human resource activities to keep employees motivated based on the service sector, which is the largest group affecting economic growth in India. In the study, human resources departments took the initiative to understand the demographics of the employees and to confirm the accuracy of leadership theories of what motivated employees to increase productivity, attendance, and revenue. Poornima's findings were that "factors that motivate the present-day employee are [the realization of] social, self-esteem, and self-actualization needs" (p. 27).

Although compensation is a source of motivation, its contribution to the larger scope of motivation is unclear. Poornima (2009) noted, "The contribution of an employee to the organization is noted by the return that the organization pays by way of salary or

monthly wage" (p. 27). Nevertheless, the wage on its own is not the total of an employee's compensation. In addition to added employee benefits, there are intrinsic benefits such as "awards, recognitions, memberships to professional and recreation clubs, opportunities for growth, organization culture, values, company reputation, learning environment, supporting environment, work profile, ATMs, and cafeteria" (p. 27). Additional motivators include holidays, vacations with pay, memberships in clubs or gyms, retirement accounts, and other elements. Juggling the various benefits to continue to motivate employees is continuous. Jobs are considered healthy when they are "challenging, when the content of the jobs is relevant, and when the employee can see a reason for doing the job" (p. 36).

Employee Satisfaction

To Maslow and Stephens (2000), "Human beings aspire to become self-actualizing" (p. 1), the point at which a person overcomes personal challenges and reaches goals. Maslow's hierarchy of needs comes from his theory (as cited in Sadri & Bowen, 2011) that there are five fundamental levels of human need, ranging from the physiological need for safety through love, belonging, and self-esteem to the greater need for self-actualization and creativity (p. 45). Within Maslow's hierarchy, the need to reach a higher level can apply to motivating employees, and health care benefits can satisfy the need for safety. The behavior of employees according to organizations will vary, but it is the larger perception created by sectors to please and motivate employees that define an entire system. Although there are motivations defined by individuals within an organization, the organization can also drive the motivation of employees.

Bandura (1977) added another perspective to the theories of human behavior: "Some theorists [hold] that motivational forces in the form of needs, drives, and impulses, frequently operating below the level of consciousness, [are] the major determinants" (p. 2) in change or reactions to changes in the work place. According to Applewhite (1965), the terms "morale [and] satisfaction [are used] at one time or another to indicate feelings of contentment, [and] satisfied workers produce more than unhappy ones" (p. 6). In summary, Applewhite believed the terms "morale" or "satisfaction" used to describe a state of contentment narrow the scope of measuring and understanding the role of satisfaction found in the component of benefits. Breaking down the components of benefits, overall, promotes a more simplified understanding of its parts.

Satisfaction is not the same as *happiness* with the job because of such things as hours, atmosphere, or having a short commute. The satisfaction found in the makeup of the job and the factors contributing to motivation are typically referred to as either intrinsic (internal) or extrinsic (based on outside elements). Bandura (1977) discussed the sources of motivation coming from "needs, drives, and impulses" found in the recesses of the consciousness. Bandura noted

> Since the proponents of this school of thought (motivators coming from the recesses of an individual's consciousness) consider the principal causes of behavior to be forces within the individual, that is where they look for the explanations of why people behave as they do [and make the decisions they make]. (p. 2)

Health Care Benefits and Their Impact on Employees

Knowing what affects employee satisfaction with health care benefits can provide information that enables employers to make better decisions about the work place in general. Understanding the specific impact health care benefits make on employees' daily decisions and long-term plans enables organizational designs to evolve over time and according to needs. By changing with the economy and employee preferences, policymakers can continue to develop the most effective health care benefit scenario. In designing the best heath care benefit scenario, employers can consider whether employees are primarily motivated by intrinsic elements or ultimately by salary.

Bandura's (1977) theoretical contribution to understanding organizational behavior as it relates to employee behavior was in social learning theory analysis. Social acceptance as a concept or system is found in the methods by which individuals learn from and interpret certain determinants. Based on the level of acceptance or internalization, individuals are then able to direct their paths. Bandura asserted that the way people and their environment interconnect is "reciprocal" (p. 195). The way employees perceive or accept the health care benefits offered will affect their satisfaction. As such, knowing the direct impact the benefit will have on day-to-day employee performance and satisfaction will affect both the short- and long-term decisions of an organization. Employees usually have one perception of typical decisions, and organizations have another, a situation that can create conflicted interactions.

An added issue for employer and employee is the role health care benefits serve within an organization and with its stakeholders, a condition that is deeper than may be

realized. Hernandez and McDonald (2010) examined employee satisfaction according to the specific industries of health care, retail, and hospitality along with the costs and benefits of people with and without disabilities. They acknowledged that employers are concerned that people with disabilities create a greater cost to the organization compared to those who are healthier. Their research across industries, however, found no evidence to justify such a concept. From empirical research and information from business and trade journals, they concluded that the performance of workers with disabilities "was rated positively, and workers with disabilities were viewed as dependable, loyal, and responsible" (p. 15).

Matthews (2010) noted that disability insurance benefits in both the private and public sectors are becoming harder to find. Such a challenge has forced consumers to join a larger population wanting to purchase insurance coverage on their own in the event of a health condition prohibiting them from working. Matthews stated, "Policies may include conditions that make it tough for people filing claims to actually qualify for the benefits" (p. B12). The government, according to Matthews, can provide Supplemental Security Income (SSI) benefits only to those "with a condition that is either expected to leave them unable to work for at least a year, or is terminal" (p. B12). Due to rising costs, cases filed, and pending cases, both employees and the government have experienced consequential expenses. The government, Matthews said, "expects [SSI] claims to jump to 3.3 million" during fiscal year 2010 from "2.6 million two years earlier" (p. B12). Program administrators attribute the increase in rising claims to awareness of the benefits.

In a Madison, Wisconsin, Associated Press (2011) report, the number of people with severe illnesses who used state insurance was reported to have increased significantly due to their ineligibility for commercial insurance. According to the Legislative Audit Bureau of Wisconsin's Health Insurance Risk-Sharing Plan Authority (HIRSPA), those responsible for providing medical and prescription drug coverage with the state for those with severe conditions noted in a recent study that "18,965 people had enrolled in the plan as of the end of the year [which] was up nearly 16 percent from December 2009" (p. 1). At the end of first quarter 2011, at least 20,300 people were enrolled in a state insurance program according to the HIRSPA report, which showed a 7% increase in people joining state insurance plans. In the same HIRSPA report, claims of $50,000 and more were also on the rise (Associated Press, 2011). Program administrators have attributed these rising claims to the fact that awareness of the benefits prompts some people to use them when they are not called for.

Silcox (2009) also noted the value organizational leaders and employees had discovered in promoting a healthy and health-conscious environment: "To be truly effective, interventions need to have both an individual and organizational focus and be embedded in an organization's culture" (p. 31). Organizations must factor in the cost benefit of improved employee health compared to not paying health care premiums. Saving money by not paying for employee health benefits with the result of poor employee health and lost productivity would be losses to a company.

Gerde (2001) found in an empirical study across corporate groups the trend was leaning toward stakeholders internally and externally expecting more "socially

responsible" (p. 472) behavior. The consequence was that corporations not responding to the pressure to accept their social responsibilities to its employees "risked losing legitimacy" (p. 472). The consequences of not accepting this responsibility are difficult to recover from, depending on the severity of the response from stakeholders.

Dulebohn, Molloy, Pichler, and Murrary (2009) declared that employee benefits are among the "most relevant for remaining competitive in the labor market" (p. 86). The design and marketability of both direct and indirect compensation have an influence on attraction and retention across organizations and sectors alike: "It is particularly true for costly benefits such as health insurance and pension plans, the provisions of which are an increasingly important issue to both employers and employees" (p. 86). These line items heavily affect an organization's bottom line, but the consequences of not providing these benefits could cost the company more than the initial layout would have cost.

Using information from an online survey, Haren and McConnell (2009) evaluated the relationship between health care insurers and employers to determine suitable benefit designs and cost sharing for products and services that satisfied employees. The goal was to understand the interaction between stakeholders as well as to keep employees' interests central to health care benefit designs. They learned that employees should be part of the makeup and creation of how health care benefits are structured. The reason for employee involvement in the process was to contribute to employee awareness of the costs as well as the benefits, to allow employees to assume some responsibility for the expenditure, and to allow them to understand how the company makes decisions.

Singleton (2010) maintained, “Employers have remained hesitant to pass along too many costs to employees, fearing that high out-of-pocket costs will translate into reduced adherence and, ultimately, deteriorating employee health and productivity” (p. 70). Today, the views and designs of employers, insurers, and employees can certainly affect how health care facilities provide medical care. What employees pay for health care insurance after the ultimate design is determined may have a domino effect.

Inadequately addressed is the issue of health care benefits and the impact on JS if ethical implications are not considered. When an organization does not approach the topic of effectively and efficiently designing health care benefits in an ethical, socially responsible manner, organizational policies are not grounded. The various characteristics that may comprise a valuable health care benefit package will vary from organization to organization. Some components will appeal to some employees and be of little value to another. It is, however, the responsibility of the organization to design a health care benefits package that gives employees viable choices. The goal is to strive for that balance between a fiscally responsible health care benefits packages that is relevant to most employee needs.

The purpose of the health care benefit design is to strike an optimum balance between what the organization can fiscally afford to spend and satisfying the medical treatment its employees need. Knowing the costs, not necessarily understanding the medical condition specific to the employee, but appreciating the financial burden on employees and their families can lead to effective design of an organization’s health care

benefits program. It can also contribute to employee satisfaction and less resistance to paying the cost of their share of these benefits.

Health Care Reform—The PPACA

A strong influence on an organization's actions to change and direct benefits comes from what Peterson (2011) referred to as the "seventh significant episode of health care reform debate in a century" (p. 429). Peterson based his comment on what the federal government has tried to do—including passage of the current health care reform legislation in March of 2010. Employees' growing yet changing needs for better health care benefits paralleled by the actual benefit provided has paralleled the downturn in the economy. The need for high quality benefits had grown into a movement across the United States, Brown (2011) observed. Against huge historical and situational odds, the president and congress steered into law new provisions and programs that, if they survive, will (among other things) bring health care coverage to roughly 95% of the U.S. population and greatly modify the rules by which private insurers enroll subscribers and price products. (p. 419)

In an article in *The New England Journal of Medicine*, Jost (2010) expressed concern for the practical implementation of the PPACA passed by Congress. The concern was that as of January 2010, not enough attention had been given to the implementation and enforcement of the act. The essential structure includes "health insurance and underwriting reforms, insurance exchanges, subsidies to make insurance affordable, individual mandates, and penalties for large employers who fail to insure their employees" (p. e 2). Jost (2010) was also concerned about enforcement of the legislation,

specifically at the federal and state government levels, which are quite different. Because of the many variations of health insurance benefits, some states have been left uncovered. The solution at the time was dependent upon whether "the final legislation [was] closer to the House or the Senate approach" (p. e 2). Many states are still working to define the bill as it relates to the state's needs and policies.

Ramifications of the reform mean different things to politicians, government officials, the media, health care providers, private insurers, organizational leaders, employees, and the companies that offer health care benefits as part of an employee's compensation package. Singleton (2011), Peterson (2011), and Brown (2011) all mentioned the angles from which many can benefit from the improved health care system plan proposed and passed through the current administration, something that has been in formative stages since the 1930s. Many social welfare programs were passed during this period, and President Franklin D. Roosevelt had also considered it, but he "had not thought it possible to create a national health care related coverage because of the intense opposition he thought it would create" (Odier, 2010, p. 280).

Concerns mentioned by Jost (2011) and Singleton (2010) regarding the implementation of each aspect of the PPACA from the Senate and the House of Representatives addressed uncertainty about the reform. The issue blocking an amicable solution was how to repair past issues and resolve the problem of accessibility without leading to higher costs or lower quality. "Conversely, reducing costs without reducing accessibility theoretically requires a reduction in quality or some other form of rationing" (Singleton, 2010, p. 208). Without, therefore, taking away from the overall

quality or actual cost individuals ought to continue to have the necessary amount of access to health care providers or prescription coverage in order to restore the individuals' level of health. The assurance of not having to sacrifice one for the other ought to be a given- low cost equating to less access to health care providers, medical attention or prescriptions

Health Care Cost Coverage Cycle

Singleton (2011) pointed out the need for accountability in quality of service and delivery of services to those who had health insurance. That means there must be a mechanism in place to monitor treatment and costs so that beneficiaries receive the needed services, and the policies pay the fair price for them. Employers must be willing to work with insurance companies as they both factor in the needs of employees in the design of health care benefit packages. Employer and employee then share the cost of delivering the service, with the employer typically bearing the larger share of that cost.

Another problem Singleton (2011) addressed is compromised delivery of health care or the "adverse effect" (p. 210) of the costs of the uninsured being indirectly incorporated into the costs of the insured. A balance for unrecovered expenses by health care providers and organizations can be recovered on the end of the insured individuals according to Singleton through what is called "cost-affected" expenses, which are increases in compensation for insurance plan-covered services. "Every year, the uninsured receive an estimated $56 billion in uncompensated care" (p. 210), costs that are a greater portion of higher insurance premiums that are then passed on to those who have health insurance. This rise in health care cost reciprocally affects the way health care

plans are designed and contribute to a negative correlation. As the costs of care for the uninsured rise, other health care costs also rise to cover these costs, which may ultimately decrease the quality of coverage provided by insurance companies through employers. These added costs create a greater burden on the insured to cover the additional expense in an already cash-strapped economy.

The employer must choose between insurance plans that match a cost-benefit analysis while providing an appropriate investment in quality health care for the sake of employees. In this design, a mutually feasible plan, ought to be inclusive of the delivery of care and recovering costs to an appropriate dollar amount suitable for insured payees. Aggregate trends of "employee retention" weighted against employer expenses are used to justify an investment that is economically sensible for the employer. These aspects determine the type and quality of the insurance plan that is offered. From the employee's perspective, compensation beyond the monetary reimbursement in the form of high health care quality can affect how much effort they apply to their work. This condition can be seen in job performance, productivity, attendance, and other variables contributing or leading to JS.

Singleton (2011) viewed the level of demand the cost of health care places on employers relative to the overall operation of their organizations.

> In 2007, health care costs constituted $1,525 of the price of every General Motors vehicle, [as] GM spent $4.6 billion on health care in 2007, an amount greater than what the company spent on the steel used to produce automobiles. (p. 211).

This cost was said to have created a "$5 billion disadvantage for GM against Toyota, which spends $1,400 less on health care per vehicle" (Singleton, 2011, p. 211). Factoring in this cost, employers are making the tough decision of lowering the cost of providing insurance "from nearly 70 percent to 60 percent" (p. 211).

Costs to employees show a ripple effect on what the health insurance policy will cover, deliver, and bill. Home life health care needs and family communication are also affected by the quality of insurance, if it exists, and the general ease and use of the benefits as well as overall cost. Home life can be quite an influence on work performance and, in turn, the larger plan of healthcare design.

Work performance is also associated with the degree of stress as supported by the literature. Workplace stress impacts health, according to Jepson and Forrest (2008), and Largo-Wight, Chen, Dodd, and Weiler (2011). When a work environment is mismanaged, it can generate many negative outcomes: poor productivity, higher stress levels, and greater dependency on health care benefits. In reconciling these differences employers can start by investing in options to increase the likelihood of a positive outcome for both employer and employee. The concept of a perpetuated cycle of stress feeding into a system of poorly designed and implemented health care and an organization without solutions to stress will only continue without the adequate amount of attention to details. The ultimate design of health care benefits affects the state of stress or health in an organization.

The "Wild Card" Solution

Saver (2011) devised a concept called a "wild card" to resolve aspects of health care reform effectiveness. He saw the problem as the need for organizations to find a happy medium between the cost of providing health insurance to employees without adding to the cost of operations while keeping employees positively engaged and motivated.

Mercer's recession survey results showed:

> Nearly two-thirds of all respondents [may now be asking] employees to pay a greater share of health plan costs, most commonly by requiring them to pay a higher portion of the monthly premium (40%) and/or by raising deductibles, copays/coinsurance or out-of-pocket maximums. (Domaszewicz et al., 2010, p. 29)

The issues of transferring health plan costs to employees in higher premiums or increased deductions come with recommended solutions by policy makers and social scientists. Saver described the wild card as using creative effective research (CER), one that would be comprehensively investigated by a team of legal department members in the organization that would compare treatments to determine which interventions work best. "The story of how CER morphed into a symbol of crude rationing schemes and government interference with the doctor-patient relationship offers a cautionary lesson about the limits of pragmatic problem solving in an era of partisan polarization" (Gerber & Patashnik, 2010, p. 1) Gerber and Patashnik (2010) noted that CER in its original state, before losing momentum to political tugs of war, appeared to offer a viable plan for

tightening the cost structure and delivery of quality health care. That plan was for stakeholders to have a say in making decisions in both the short and long terms. The goal of CER was to improve the quality of the overall administration and provision of insured health care.

Another plan to offset the staggering cost of health care of employees, especially those preparing for retirement, was to create a savings plan for future health care costs while the employee was still working. If it worked, the plan would be structured to anticipate and account for rising costs. The U.S. Census Bureau estimated that non-Hispanics 65 or older will show a 19% population increase by 2050, for a total of 71 million people (Vincent & Velkoff , 2010, p. 6). The effects of this increased number of beneficiaries would confound the system as it is structured today.

As the aging population increases, companies serving baby boomers, organizations, and government officials anticipate cutting back on health care benefits (Fay, 2011). One solution offered is a health savings account (HSA). Fay (2011) noted that the HSA was introduced in 2004 to balance putting aside funds for the upcoming cost of retirement while still making use of the health care plan. The health care plan, said to offer lower base costs than traditional group health insurance, can possibly balance the higher deductibles traditionally charged with other health care savings plans. The plan works by individuals contacting the organization representative to identify the specifics the health care benefits offered and to learn whether an HSA is not provided. If a HSA is not provided, other options can be explored.

Domaszewicz, Havlin, and Connelly (2010) advised individuals to treat health care benefits as a product and respond as consumers in the market for the most viable and fiscally balanced product (p. 29). Often, employers move to devise creative ways to lower cost in an effort to balance or at times transfer costs to the employee. In one survey, Mercer (as cited in Domaszewicz et al., 2010) noted that nearly a fifth of 1,562 early respondents had eliminated high costs or generous health plan options, a fact observed in 3,000 organizations surveyed. Organizations using consumer-directed health plans (CSHPs) or an HAS are said to have high deductibles to encourage employees to factor costs when selecting a medical plan.

A stipulation put into effect in 2011 and included in the PPACA is that employees' children up to the age of 26 can be covered under the employee's insurance. As a result, "health plan enrollment grew by an average of 2% in 2011" (Mercer, 2011, p. 1). Changes taking effect in 2014 will ask "employers to extend coverage eligibility to all employees working at least 30 hours per week on average and auto-enrolling newly eligible employees" (p. 1). Employers are concerned about keeping up with the volume of changes and the layering of added costs to already recession-imposed demands. What is unknown is where the revenue is going to come from to cover the multiple changes and provisions imposed.

Personality and Job Satisfaction

Personality traits and characteristics interact to produce different perceptions of subjectively defined experiences. Interactions between individuals and situations and individuals and individuals affect processed information (Mischel, 1979). Three segments

of cognition and personality interfaces defined by Mischel (1979), each aspect referred to as a principle established various states of awareness, morality, and satisfaction identifying the respective advantages and disadvantages in defining a situation. The primary principle of interest deals with "cognitive economics: the recognition that people are flooded by information which must somehow be reduced and simplified to allow efficient processing and to avoid an otherwise overload" (p. 741).

The subject of health insurance and the pressures of the workplace can cause an overload of information that may require a person to process large amounts of information into manageable portions. As workplace pressures vary, so may the load of family commitments, economic compensation, work hours, and personal expectations, all of which can create a more complex processing of how to select health care benefits—if the option is offered.

Inclusive of careers in general, certain themes remain commonplace despite the particular field or industry. On the topic of JS, the application of theories presented by Mischel (1979), offer a deeper meaning to themes and patterns found in how individuals respond to the pressures and commitments of their professions or jobs. There can be a greater meaning to more extensive associations of employees finding comfort, satisfaction, or contentment in a job as supported by Berry, Chiaburu, Gardner, and Li (2011); Gallagher, Fleeson, and Hoyle (2011); and Carroll, Cellar, Nelson, and Yorke (2004) in recent studies of the five-factor model of personality traits. The five-factor model refers to openness, conscientiousness, extraversion, agreeableness, and neuroticism as it relates to the essentials and operations of behavior as incorporated in a

larger study dealing with accountability of citizens (Chiaburu, Oh, Berry, Li, & Gardner, 2011). This, accountability, becomes relevant in better understanding the rationale of an individual responding to the specifics of situations.

Each profession carried with it some degree of stress and anxiety. Obstetric and gynecological medical specialists (OB-GYNs) and librarians work in two seemingly unrelated fields, and limited data support a comparison connecting levels of JS and motivation between these two professions. OB-GYNs, "who attend the majority of childbirths in the United States and provide the most clinically complex obstetric procedures, are struggling with increasing malpractice insurance premiums and litigation risk" (p. 229), as noted in a recent study by Xu, Siefert, Jacobson, Lori, and Ransom (2008). These burdens and added daily stressors to the already challenging demands placed on a clinician affect earnings, break down physician-patient care relationships, and debilitate medical discretionary abilities. The Xu et al. study provided empirical evidence of the "negative impact of medical liability burden on OB-GYN satisfaction with their work" (p. 230). Too often the clinician struggles with providing premium care in a setting where all else works against generating positive patient feedback and experiences.

The Karsh, Beasley, and Brown (2010) physician satisfaction survey, job and organization predictors bring to light enhanced satisfaction and decrease the changes of "burnout and turnover" (p. 458). Although Karsh et al. did not see a great deal of attention placed on physician commitment to the organization, further observation showed that apart from health commitment, employee attitudes are rated among top contenders for satisfied employees. The two key variables, an employee's level of

commitment to the organization and employee attitude, are said to positively affect "a variety of important behavior such as performance, turnover, absenteeism, and helping behavior" (p. 458). The importance of an employee's level of commitment to the organization and overall attitude impacts the level contributing JS. This, contributing attitude to job satisfaction, too must be factored.

Summary and Transition

The literature reported here has included studies that took differing approaches to evaluating the levels of satisfaction in the workplace. Some measured specific job titles or job levels in particular industries, compared certain industries to other industries, and compared high stress job categories within specific organizations. Many other variables were also considered within these comparisons. Peters, Chakraborty, Mahapatra, and Steinhardt (2010) evaluated the level of JS within the specific category of health workers in both the private and public sectors, using a cross sectional survey of 1,916 respondents in Andhra Pradesh and Uttar Pradesh, India. To execute this study, each organization in each of the sectors took slightly different approaches to maintain a standard protocol when carrying out the study, as a "sampling frame of health providers did not exist" according to Peters et al. (p. 11). Quantitatively investigating JS among private sector employees and the prospective health care benefits offered based on variables such as age, gender, and job title may influence correlation variance.

Chapter 3 will describe the specific proposed research method, identify variables, and describe instrument selection and design. It will also articulate the role of the researcher in carrying out the study.

Chapter 3: Research Method

Research Design

The quantitative analytical approach I judged most suitable for the study was a survey of employees and employers in the private sector to learn their opinions of and experiences with health care benefits. I was unable to secure an existing survey that isolated the effects of health care benefits on employment decisions and employees' overall JS. For that reason, I created a survey (Appendix A) that asked employees to rate their satisfaction with the health care benefits (SWHCB) provided by their employers. I used a second survey called Jobs In General (Appendix B) provided by The University of Bowling Green (BGU) to collect additional data (see Appendix C for permission to use survey note from BGU). A case study can uncover specific scenarios. In this case, I used the approach to learn the effects of health insurance on a particular group: employees who have employer-provided healthcare benefits.

Role of the Researcher in Data Collection

My role as the researcher was to administer the questionnaire and analyze the results. The Walden University participant pool provided a large general population that prevented any biased isolation of a particular group or organization. I received the Walden Institutional Review Board (IRB) approval, number 10-24-12-0122744, before I contacted any potential participants or collected any data. In completing the IRB approval process, I also obtained a National Institute of Health (NIH) certificate as seen in Appendix D. As the researcher, I requested a change in procedure to add a second source to obtain additional participants to the study. IRB approval was also needed for this

request to select a second source. The survey was then sent out to Academy of Management electronic mailing lists, with identities of participants known to the researcher but kept confidential to protect the credibility and integrity of the data collected.

Research Design and Approach

I asked a panel of three health care benefits experts to review the survey for face validity to establish whether the SWHCB score would measure what it was intended to measure. The panel suggested revisions, additions, and deletions of items on the questionnaire, which were then reviewed and modified as needed.

I also used survey information from Walden participant pool volunteers to measure the internal consistency reliability of the SWHCB score. Each participant completed the Employer-Provided Healthcare Plan Satisfaction Survey (hereinafter called survey), and data were analyzed using Cronbach's alpha. If Cronbach's alpha was greater than 0.7, then the survey was considered reliable. Otherwise, I conducted an item analysis in an attempt to maximize the internal consistency reliability of the score. In the methodological investigation, I used a Pearson's correlation and multilinear regression for this categorical dependent variable study. The goal of using a quantitative approach was to have numerical values to compare past studies with new quantitative results. Using an objective analysis allowed a systematic assessment of the influence specific variables had on satisfaction with health insurance benefits.

I selected a quantitative method for several reasons. In a quantitative approach, a large number of respondents can be contacted without their being identified, using a

consistent format and an online survey tool. The responses can then be used to tabulate a specific value, which in this case was Cronbach's alpha. The study can then be repeated using the Cronbach's alpha value as a source for a viable comparison. In a quantitative study, questions on a Likert-type scale can be used to measure the degree of satisfaction based on any number of variables such as age, gender, ethnicity, or geographic location.

Measures

Independent Variable

The independent variable was *satisfaction with health care benefits*, which was measured on a scale of 1 to 5, with 1 being *very dissatisfied*, and 5 being *very satisfied*. The score was derived by calculating the average of questions 1 through 10 on the survey. Lower scores indicated less SWCB, while larger scores indicated greater SWCB.

Moderating Variables

The moderating variables were *age* (age), *gender* (gen), and *job title* (JT). Age was measured in years on a continuous scale, and gender was indicated as male, female, or prefer not to answer. The variable of gender was measured on a categorical scale with three categories. The study participant's gender was recorded as either 0 = *female*, 1 = *male*, and 2 = *prefer not to answer*. The job title was measured on a categorical scale with two categories: 0 for *front line employees* and 1 for *supervisory or managerial positions*.

Dependent Variable

The dependent variable of *job satisfaction* was measured on a continuous scale with a range of 0 to 54. The score was derived by computing the total of items 1 through 18 from the Job-in-General questionnaire. Negatively worded items (Questions 1, 3, 5, 7,

9, 10, 11, 13, 15, and 17) were reverse coded before I computed the score. Response choices were 1 = *Yes*, 2 = *No*, and 3 = *?* Lower scores indicate less JS, while higher scores indicate more JS.

Research Questions

The overarching research question asked what, if any, correlation is there between JS and the level of SWCB. The following were the research questions:

Research Question 1: Is there a correlation between JS and the level of SWHCB?

Research Question 2: Does age moderate the relationship between JS and the level of SWHCB?

Research Question 3: Does gender moderate the relationship between JS and the level of SWHCB?

Research Question 4: Does job title moderate the relationship between JS and the level of SWHCB?

Research Question 5: Do age, gender, job title, and the level of SWHCB collectively predict JS?

Research Hypotheses

Five statistical hypotheses were tested in this study.

H_{10}: There is no correlation between JS and SWHCB.

H_{1a}: There is a correlation between JS and SWHCB.

H_{20}: Age does not moderate the relationship between JS and SWHCB.

H_{2a}: Age moderates the relationship between JS and SWHCB.

H_{30}: Gender does not moderate the relationship between JS and SWHCB.

H_{3a}: Gender moderates the relationship between JS and SWHCB.

H_{40}: Job title does not moderate the relationship between JS and SWHCB.

H_{4a}: Job title moderates the relationship between JS and SWHCB.

H_{50}: Two or more of the independent variables, *age, gender, job title,* and *SWHCB* do not better predict JS than any single independent variable alone.

H_{5a}: Two or more of the independent variables, *age, gender, job title,* and *SWHCB* better predict JS than any single independent variable alone.

Data Analysis

All statistical analyses were performed using SPSS 19.0 for Windows. All analyses were two-sided, with a 5% alpha level. Demographic variables were summarized using the mean, standard deviation, and range for continuous scaled variables and frequency and percent for categorical scaled variables. I used Cronbach's alpha to measure the internal consistency reliability of the satisfaction with health care plan and JS scale scores.

I tested Hypothesis 1 using Pearson's correlation coefficient. If the Pearson correlation coefficient was statistically significantly different from zero, then the null hypothesis would be rejected, and it would be concluded that there is a correlation between JS and satisfaction with the health care plan. The strength and direction of the relationship between JS and SWHCB are reported in Chapter 4.

I tested Hypothesis 2 using multiple linear regression analysis. The dependent variable in the regression model was the *JS score*. The independent variable was the *SWHCB score*. The moderator variable was *age*. The interaction between SWHCB and

age is of primary importance. If the interaction term is statistically significant, then the null hypothesis will be rejected, and it will be concluded that age moderates the relationship between JS and SWHCB. The equation of the model is reported in Chapter 4, and statistically significant regression coefficients are interpreted. The *R* square for the final model will also be presented and interpreted.

I tested Hypothesis 3 using multiple linear regression analysis. The dependent variable in the regression model was the *JS score*. The independent variable was the *SWHCB score*. The moderator variable was *gender*. The interaction between SWHCB and gender is of primary importance. If the interaction term is statistically significant, then the null hypothesis will be rejected, and it will be concluded that gender moderates the relationship between JS and a SWHCB. The equation of the model is reported in Chapter 4, and statistically significant regression coefficients are interpreted. The *R* square for the final model will also be presented and interpreted.

I tested Hypothesis 4 using multiple linear regression analysis. The dependent variable in the regression model was the *JS score*. The independent variable was the *SWHCB score*. The moderator variable was *job title*. The interaction between SWHCB and job title is of primary importance. If the interaction term is statistically significant, then the null hypothesis will be rejected, and it will be concluded that job title moderates the relationship between JS and SWHCB. The equation of the model will be reported in Chapter 4, and statistically significant regression coefficients will be interpreted. The *R* square for the final model will also be presented and interpreted.

I tested Hypothesis 5 using stepwise multiple linear regression analysis. The dependent variable in the regression model was the *JS score*. The independent variables were the *SWHCB score*, *age*, *gender*, and *job title*. All four independent variables were entered into the stepwise model selection procedure. If the regression coefficients for two or more independent variables are statistically significant, then the null hypothesis will be rejected, and it will be concluded that combinations of the independent variables better predict JS than any single independent variable alone. If one or fewer independent variables are statistically significant, then it will be concluded that combinations of independent variables do not better predict JS than any single independent variable alone. The equation of the model will be reported in Chapter 4, and statistically significant regression coefficients will be interpreted. The *R* square for the final model will also be presented and interpreted.

Instrumentation and Materials

To carry out the study, I used two survey instruments: the Job-in-General 18-item survey to assess the quality of JS and the researcher-designed survey used to assess employee level of satisfaction with their health insurance benefits. The survey design by the research used wording to address each component measured in the study.

Sample Size Justification

Based upon previous dissertations that used participants from the Walden University participant pool, it was anticipated that a sample size of approximately 150 would be achievable. Announcements and reminders were posted on the Walden participation board. A reminder was sent out to those who previously committed to

completing the study to return in a timely manner. If the appropriate completed surveys were not completed, a second source was identified through the Walden University participant pool. The second source identified was the Academy of Management through the organization's many professional electronic mailing lists. Responses to the survey were immediate and complete. The assumption is that respondents completed the survey with complete honesty and according to the guidelines defined in the consent form (See Appendix E). Using both the Walden participant pool and Academy of Management led to meeting the sample size goal.

Hypothesis 1 was tested using Pearson's correlation coefficient. According to Cohen (1988), small, medium, and large effect sizes for hypothesis tests about the Pearson correlation coefficient are $r = 0.1$, $r = 0.3$ and $r = 0.5$ respectively. A sample size of 150 produces 80% power to detect an effect size of 0.23, which is a medium effect size. For example, if the true population correlation between JS and health insurance benefits is 0.23 or greater, this study will have an 80% chance of detecting (i.e. achieving statistical significance) the correlation at the 0.05 level of statistical significance.

Hypotheses 2 through 5 were tested using multiple linear regression analysis. Power analysis for multiple linear regression is based on the amount of change in R^2 attributed to the variables of interest. The variable of interest is the interaction between health care benefits and age. According to Cohen (1988), small, medium, and large effect sizes for hypothesis tests about $R^2$are $R^2 = 0.0196$, $R^2 = 0.13$ and $R^2 = 0.26$ respectively. A sample size of 150 achieves 80% power to detect an R^2 of 0.045 (which is a small-to-medium effect size) attributed to one independent variable (e.g. the interaction between

age and health care benefits) using an *F* test with a significance level (alpha) of 0.05. For purposes of this power analysis, it was assumed that the R^2 attributed to the other two variables (*age* and *health care benefits*) was 0.10. If the R^2 attributed to the other two variables is greater than 0.10, the power to detect a statistically significant effect caused by the interaction between age and health care benefits will be greater than 80%. Thus, a sample size of 150 is justifiable for detecting small-to-medium effect sizes for each hypothesis tested in this study.

Measures for Ethical Protection of Participants

Participants were recruited from a volunteer pool, and names of those who completed surveys were unknown. For that reason, there is no way to associate participant responses or identities with the survey results.

Summary and Transition

In Chapter 3, I evaluated the quantitative methodological approach used for this study. Moderating variables of age, gender, and job title were identified to better understand the relationship between employee job satisfaction and health care benefits. Survey design and implementation were established along with justified sample size. Chapter 4 will provide a description of the data collection and interpretation of the results. Final chapter concludes with recommendations, implications for positive social change, and recommendations.

Chapter 4: Results

Chapter 4 is a report and interpretation of the strength and direction of the relationship between SWHCB and JS among employees in the private sector. This quantitative study provides added perspective using multilinear regression with the variables of *age*, *gender*, and *job title*.

Data Collection

Expert Review and Pilot Study

I first conducted a pilot study to establish reliability with certainty based on the Cronbach's alpha reported as >.7. An expert review established the face validity of the researcher-designed portion of the study. After each aspect of reliability and validity was established for the survey, the JIG section was added and distributed to the larger participant pool. The pilot study that was initially distributed to the participant pool generated the necessary responses to determine reliability. Allowing for only a single response from each participant protected the integrity of the data.

Larger Survey and Study

A total of 153 people attempted the surveys. Among the 153 respondents, 14 skipped questions on the JIG. For those participants, missing values were replaced using mean substitution. If between one and three questions were left blank, the average of the responses was used to replace the missing values for that participant. Two surveys were omitted from the analysis because six or more questions were not answered. Thus, the final sample size for the study was $n = 151$.

Demographic Variables

Among the 151 study participants, 92 (61%) were female, 58 (38%) were male, and 1 (1%) did not report gender. Only 5 (3%) were between the ages of 18 and 24; 34 (26%) were in the 25-34 age range; 48 (32%) in the 35-44 range; 37 (25%) in the 45-54 range; 20 (13%) in the 55-64 range, and 7 (5%) were between the ages of 65 and 74. The majority of study participants, 97 (64%) reported their job title as "employee," 29 (19%) as supervisor/manager; 19 (13%) as director, and 3 (2%) as CEO/president. See Appendix F for detailed frequency tables for all survey questions.

Descriptive Statistics for the Independent and Dependent Variables

Table 1 shows descriptive statistics for the independent and dependent variables. Smaller scores for the JIG indicate less job satisfaction, while higher scores indicate more job satisfaction. Considering the smallest possible score for JIG was 0 and the largest possible score was 54, job satisfaction was rated relatively high on average, with an average (and standard deviation) of 42.2 (*sd* =12.7) and a range of 0 to 54. Smaller scores for the SWHCB indicate less SWHCB, while larger scores indicate greater satisfaction with the health care benefits plan. The smallest possible score for SWHCB was 1.0, and the largest possible score was 5.0. On average, SWHCB was only slightly above the middle score of 3.0, with an *SD* of 3.2 (.94) and a range of 1.0 to 5.0.

Table 1

Descriptive Statistics for Independent and Dependent Variables

	N		Mean	*sd*	Min.	Max.
	Valid	Missing				
JS (dependent variable)	151	0	42.2048	12.68755	.00	54.00
SWHCB (independent variable)	151	0	3.2038	.94049	1.00	5.00

Cronbach's Alpha for the Independent and Dependent Variables

I used Cronbach's alpha to calculate the JIG and SWHCB scores. Table 2 shows both scores had excellent internal consistency reliability. Cronbach's alpha was .92 for the JIG and .93 for the SWHCB score.

Table 2

Cronbach's Alpha Reliability for Independent and Dependent Variables

Variable	Cronbach's alpha (*N* = 151)	Number of items
JIG	0.92	18
SWCB	0.93	9

Hypothesis Test Results

Research Question 1. Is there a correlation is there between job satisfaction and the level of SWHCB?

This question was answered by testing the following hypotheses:

H_{10}: There is no correlation between job satisfaction (JS) and satisfaction with SWHCB.

H_{1a}: There is a correlation between job satisfaction (JS) and satisfaction with SWHCB.

I tested Hypothesis 1 using Pearson's correlation statistic. The Figure 1 scatterplot depicts the relationship between JS score and SWHCB score and suggests a positive correlation between the variables.

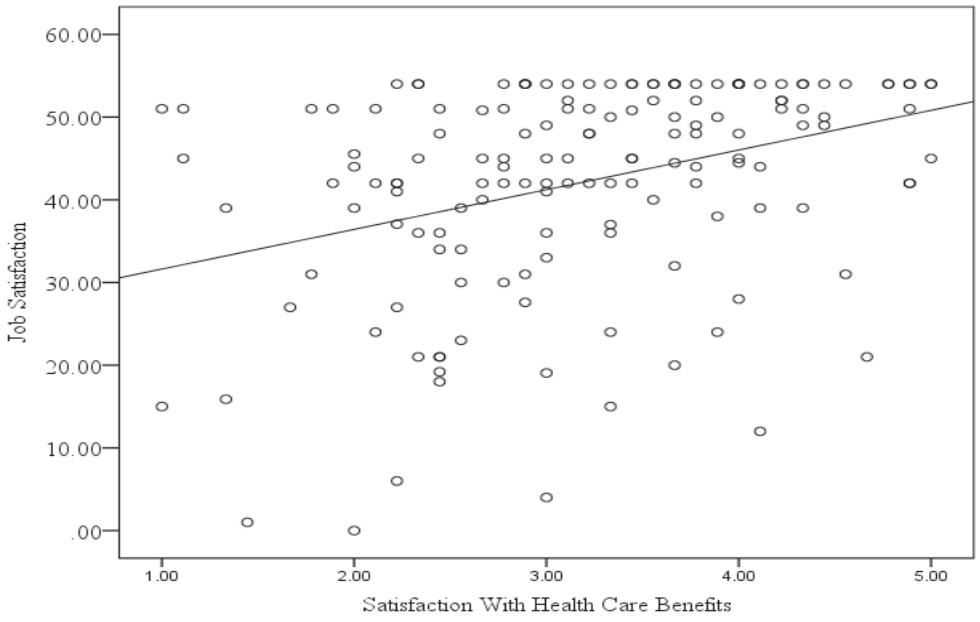

Figure 1. Scatterplot of the job satisfaction score and the SWHCB score.

Table 3 shows a statistically significant, moderately strong positive correlation between the JS and SWHCB scores, r (149) = .36, $p < .001$. The null hypothesis was rejected, and I concluded there was a moderately strong positive correlation between job satisfaction and satisfaction with health care benefits.

Table 3

Pearson's Correlation Statistic for JS Score and SWHCB Score

		Satisfaction with health care benefits
Job satisfaction	Pearson correlation	.356
	p value	<.001
	N	151

Research Question 2. Does age moderate the relationship between job satisfaction and the level of SWHCB?

This question was answered by testing the following hypotheses:

H_{20}: Age does not moderate the relationship between JS and SWHCB.

H_{2a}: Age moderates the relationship between JS and satisfaction with SWHCB.

I tested Hypothesis 2 using multiple linear regression analysis. The dependent variable was *job satisfaction score*. The independent variable was *SWHCB score*. The moderating variable was *age*. SWHCB and age were centered (subtracting the mean from each variable score) prior to computing the product of the two. The product of SWHCB and age is the interaction term that determines whether or not the relationship between JS and SWHCB is moderated by age. Table 4 shows that only SWHCB was a statistically significant predictor of JS, $p < .001$. In particular, the interaction between SWHCB and age was not statistically significant, $p = .54$. Because the null hypothesis was not rejected, I concluded that age does not moderate the relationship between JS and SWHCB. The *R* square for the overall model was .13, which means that SWHCB, age, and the interaction between SWHCB and age explain 13% of the total variance in JS scores. The final equation of the model was JS = 42.25 + 4.89*SWHCB + .13*A -

.56*SWHCB_A, where JS = Job Satisfaction; SWHCB = Satisfaction with Health Care Benefits; A = age, and SWHCB_A = the interaction between SWHCB and age. The interpretation of the statistically significant coefficient for SWHCB is, when controlling for age, the average JS score is expected to increase by 4.89 points for every one-point increase in the SWHCB score.

Table 4

Multilinear Regression of the JS Score SWHCB, Age, and the Interaction Between Satisfaction With Health Care Benefits and Age

Model [a, b, c]	Nonstandard coefficients		Standard coefficients	t	*p* value
	B	Std. Error	Beta		
(Constant)	42.254	.977		43.252	<.001
SWHCB [d]	4.893	1.055	.363	4.636	<.001
Age [e]	.134	.824	.013	.163	.871
SWHCB Age [f]	-.563	.926	-.048	-.608	.544

a. Dependent variable: JS score
b. The overall model was statistically significant, F (3, 147) = 7.24; $p < .001$
c. R^2 attributed to the overall model = .13
d. SWHCB
e. Age
f. Interaction between SWHCB and age

Research Question 3. Does gender moderate the relationship between JS and the level of SWHCB?

H_{30}: Gender does not moderate the relationship between JS and SWHCB.

H_{3a}: Gender moderates the relationship between JS and SWHCB.

Multiple linear regression analysis was conducted to test Hypothesis 3. The dependent variable was *JS* score. The independent variable was the *satisfaction with health care benefits* score. The moderating variable was *gender*. Only one study participant selected the "prefer not to say" option for gender and was omitted from the analysis. SWHCB and gender were centered prior to computing the product of the two. The product of SWHCB and gender is the interaction term that determines whether or not the relationship between JS and SWHCB is moderated by gender. Table 5 shows that SWHCB was the only statistically significant predictor of JS, $p < .001$. In particular, the interaction between SWHCB and gender was not statistically significant, $p = .70$. The null s was not rejected, and it was concluded that gender does not moderate the relationship between JS and SWHCB. The R^2 for the overall model was .13, which means that SWHCB, gender, and the interaction between SWHCB and gender explain 13% of the total variance in JS scores. The final equation of the model was JS = 42.14 + 4.79*SWHCB - .51*Gen + .81*SWHCB_Gen and SWHCB, with Gen = the interaction between SWHCB and gender. The interpretation of the statistically significant coefficient for satisfaction with health care benefits is, when controlling for gender, the average JS score is expected to increase by 4.79 points for every one-point increase in the SWHCB score.

Table 5

Multilinear Regression of the JS Score SWHCB, Gender, and the Interaction Between Satisfaction With Health Care Benefits and Gender

Model [a, b, c]	Nonstandard coefficients		Standard coefficients	*t*	*p* value
	B	Std. Error	Beta		
(Constant)	42.141	.980		43.012	<.001
SWHCB [d]	4.793	1.044	.356	4.591	<.001
Gender [e]	-.506	2.012	-.019	-.251	.802
SWHCB gender [f]	.811	2.113	.030	.384	.702

a. Dependent variable: JS score
b. The overall model was statistically significant, F (3, 146) = 7.18; $p < .001$
c. R square attributed to the overall model = .13
d. SWHCB
e. Gender (0=female; 1=male)
f. Interaction between SWHCB and gender

Research Question 4. Does job title moderate the relationship between JS and level of SWHCB?

H_{40}: Job title does not moderate the relationship between JS and SWHCB.

H_{4a}: Job title moderates the relationship between JS and SWHCB.

Multiple linear regression analysis was conducted to test Hypothesis 4. The dependent variable was *JS score*. The independent variable was the *SWCHB score.* The moderating variable was *job title* (front line employee through supervisor/managerial). SWHCB and job title were centered prior to computing the product of the two. The product of satisfaction with health care benefits and job title is the interaction term that determines whether the relationship between JS and SWHCB is moderated by job title. Table 6 shows that only SWHCB was a statistically significant predictor of JS, $p < .001$.

In particular, the interaction between SWHCB and job title was not statistically significant, $p = .93$. The null hypothesis was not rejected and it was concluded that job title does not moderate the relationship between JS and SWHCB. The R^2 for the overall model was .11, which means that SWHCB, job title, and the interaction between SWHCB and job title explain 11% of the total variance in JS scores. The final equation of the model was JS = 42.50 + 4.25*SWHCB – 1.90*Job + .20*SWHCB_Job, where JS = Job Satisfaction; SWHCB = Satisfaction with Health Care Benefits; Job = job title (0 = front line employee, 1 = supervisor/managerial), and SWHCB_Job = the interaction between SWHCB and job title. The interpretation of the statistically significant coefficient for SWHCB is, when controlling for job title, the average JS score is expected to increase by 4.25 points for every one-point increase in the SWHCB score.

Table 6

Multilinear Regression of the JS Score SWHCB, Job Title, and the Interaction Between Satisfaction With Health Care Benefits and Job Title

Model [a, b, c]	Nonstandard coefficients		Standard coefficients	*t*	*p* value
	B	Std. Error	Beta		
(Constant)	42.496	.961		44.229	<.001
SWHCB	4.247	1.041	.321	4.080	<.001
Job [e]	-1.900	2.022	-.074	-.940	.349
SWHCB_Job [f]	.195	2.212	.007	.088	.930

a. Dependent variable: JS score
b. The overall model was statistically significant, F (3, 144) = 5.90; $p = .001$
c. R square attributed to the overall model = .11
d. Job title (0 = front line employee; 1 = supervisor/managerial)
e. Interaction between SWHCB and job title

Research Question 5. Do age, gender, job title, and the level of SWHCB collectively predict JS?

H_{50}: Two or more of the independent variables of *age, gender, job title,* and *SWHCB* do not better predict JS than any single independent variable alone.

H_{5a}: Two or more of the independent variables of *age, gender, job title,* and *SWHCB* better predict JS than any single independent variable alone.

Stepwise multiple linear regression analysis was conducted to test Hypothesis 5. The dependent variable was the *JS score.* The independent variables were the *SWHCB score, age, gender,* and *job title*. Table 7 shows that only SWHCB was a statistically significant predictor of JS, $p < .001$. The null hypothesis was not rejected, and it was concluded that two or more of the independent variables do not better predict JS than SWHCB alone. The *R* square for the overall model was .10, which means that satisfaction with health care benefits explains 10% of the total variance in JS scores. The final equation of the model was JS = 28.84 + 4.26*SWHCB, where JS = Job Satisfaction, and SWHCB = Satisfaction with Health Care Benefits. The interpretation of the statistically significant coefficient for SWHCB is, the average JS score is expected to increase by 4.26 points for every one-point increase in the SWHCB score.

Table 7

Stepwise Multilinear Regression of the JS Score and SWHCB, Age, Gender, and Job Title

Model [a, b, c]		Nonstandard coefficients		Standard coefficients	*T*	*p* value
		B	Std. Error	Beta		
1	(Constant)	28.837	3.457		8.343	<.001
	SWHCB	4.263	1.036	.322	4.114	<.001

a. Dependent variable: JS score
b. The overall model was statistically significant, F (1, 146) = 16.93; $p < .001$
c. R^2 attributed to the overall model = .10

Summary

The results of the statistical analyses produced the following general findings:

1. There was evidence of a positive correlation between the variables of *JS* and *healthcare benefits*.

2. There was no evidence, using a multilinear regression analysis, independently or collectively with moderating variables of *age, gender,* and *job title,* of a relationship to SWHCB.

The results of Chapter 4 provided predictors to the decisions and implications of the practical applications of the study. Chapter 5 will be an interpretation and assessment of the data analysis as it relates to the theoretical framework of the study.

Chapter 5: Reflections and Recommendations for Further Study

Introduction

For this study, I used two instruments to learn whether the sample population believed that employer-provided healthcare benefits was a predictor of job satisfaction. The results of the statistical analysis suggested a positive correlation between job satisfaction and satisfaction with healthcare benefits, underscoring the premise that the former is strongly influenced by the latter, leading to the conclusion that those with health care benefits enjoyed greater job satisfaction.

Although having satisfied employees is important to workplace morale, maintaining a stable workforce with minimal employee turnover is important to the success of any organization for many other reasons, with work continuity and general company stability chief among them. With stability come fewer interruptions to work flow and increased time and cost savings through a reduced need to recruit and train new employees. The latter are important because recruiting and training are closely tied to the tangential benefits of product quality and consistency in manufacturing. In the service sector, positive consistency leads to better customer service. For the most efficient and profitable operations, policy makers and management need a better understanding of the reasons some employees remain in their positions, why others leave, and how workforce stability can contribute to improved "service delivery, staff workload, and the multiple dimensions of organisational *[sic]* performance, including costs" (VHA, 2002).

Ironically, in the medical services industry, for example, the costs of replacing an employee can be particularly high and usually occurs in at least five areas: the loss of the

staff member (severance pay, 401k company contributions, accrued sick leave, for example), temporary replacement costs, cost of overtime pay of other or additional staff, the costs in advertising for and selecting the replacement, and lost productivity until the replacement is hired. If loss of staff occurs in a hospital setting, for example, it can reduce the number of patients who can be served and treated, which, in turn, may reduce hospital revenue (VHA, 2002).

In 2004, as an example, nurse turnover costs in the United States were estimated at between $21,500 and $31,500 per nurse ($26,000-$38,000 in 2012 dollars), "with a rough 'rule of thumb' that the cost of staff nurse turnover normally fell between 0.75 and 2.0 times the annual salary, depending on replacement strategy and other factors" (Waldman, Kelly, Arora, & Smith, 2004, as cited in Buchan, 2010). These costs continue until the new hire reaches the same level of productivity as the staff member who left, so over several months, these costs add significantly to the cost of replacing the experienced staffer. The challenge to businesses wanting to operate at peak efficiency is how to improve employee retention through not only the workplace setting, but also through the financial benefits.

Health care costs are now the single most frequent cause of bankruptcy, with "62.1% of all bankruptcies in 2007 caused by medical debt. . . . 92% of these medical debtors involved in a bankruptcy filing had medical debts over $5000 or 10% of pretax family income" (http://www.giveforward.com/p/medical-bankruptcy/medical-bankruptcy-statistic). Because of the costs of health care, medical insurance as part of an employment package may weigh heavily when a person considers a job offer. Although

the offer of health insurance is important, the quality of the benefits themselves may be what determines whether an employee is satisfied with the job and remains with the company. Because of these important business considerations, I undertook this study to determine whether there is a positive relationship between employee job satisfaction and satisfaction with employer-provided health care benefits.

The cost of medical care has been at the forefront of political discussions for many years, but no more so than during the presidential campaigns of 2007 and 2011. When Barack Obama campaigned for the presidency, a major Democratic Party plank in both elections, wanting to make health care more affordable for Americans. When I selected the topic for this study of whether there was a relationship between job satisfaction and health care benefits, universal health care had been discussed, but there had been no legislation enacted. The bill that was finally enacted, the Affordable Care Act, was a compromise bill that did not have every benefit the president had proposed, but it did cover many Americans who had lacked health insurance of any kind.

Passage of Obamacare, as the Patient Protection and Affordable Care Act (P.L. 111-148) was nicknamed, has increased both awareness of the need for and benefits of healthcare insurance. Although it will not be fully implemented until 2014, its effects on the medical community—both fiscally and in terms of service—as well as employers who offer health insurance to employees is already changing. While there is no doubt that insurance that offsets the personal costs of medical treatment is valued by beneficiaries, the cost to an organization can be significant, and requiring them to offer it is creating dissension between the corporate and medical worlds. The 916-page PPAC is of interest

to both the Department of Labor (as it affects the workplace) and the Department of Human Services (as it affects healthcare issues). Although the Supreme Court of the United States declared the act constitutional, it is anticipated that there will be continuing challenges to many parts of it.

The cost of private health insurance is so high that employees who work for minimum wage in small businesses can often not afford their part of the cost of employer-offered health insurance, much less private health insurance. Even when they can, the cost of prescriptions, medical office visits, specialists' fees, and hospital stays will increase the employee's out-of-pocket expenses. A well-designed health care benefit plan that is balanced according to costs carried by the employer and employee promotes a prepared and equitable situation. Cost set by hospitals, insurance carriers, or companies are regulated on a well-designed plan in hopes of ensuring a fiscally manageable situation for the health care benefit plan consumer. The goal is to promote a democratized environment for both groups.

Reflection

My interest in the relationship between job satisfaction and health care benefits grew out of my profession as a Human Resource Administrator. In my experience, benefits typically appeal to more mature, experienced new hires (age 55 to 74 categories), and in this study participants were pleased with the benefits offered and it is important to factor this variable in creating a receptive and satisfied work environment. Through satisfied employees the rate of productivity is productive, organization employee retention is sustained. Supporting an organization's feasible cost containment plans

allows with heightened productivity employee morale can also generate positive returns. In my professional experience the outcome of the study provided expected results in confirming in a scientific manner the relation between the variables while providing an opening for further extrapolation and research in the future. I investigated whether there was a connection between health care benefits and an individual's perception of job satisfaction. The long-term goal was to determine an additional means for improving work place productivity, morale, and achieving the organization's optimum fiscal management.

Interpretation of the Findings

The data from this study included strong evidence that employees who are more satisfied with their healthcare benefits tend to be more satisfied with their jobs. These data did not reveal strong evidence that the relationship between satisfaction with health care benefits and job satisfaction depends on any of the variables of *age*, *gender*, or *job title*.

Limitations of the Study

I found little scholarly information about the specific influence of health care benefits on employment decisions, design of work place benefits, or whether the limitations of the health care benefit caused potential employees to reject employment offers. There is quality research material on the topic of employee benefits and the influence on perceived advantages to an employee's overall compensation design, but this material is beyond the scope of this study.

Implications for Social Change

The PPACA, which is scheduled to unfold in 2014 and continue gradually for 6 years beyond that point, was a compromise piece of legislation. It is nonetheless the law of the land, and challenges to its implementation—as with all major legislation—are anticipated. Organizations can benefit from the results found in this investigation and can expand on the basis of this study through determining the financial implications for an organization with satisfied employees along with high morale. The cost of offering health care benefits that are the budgetary standards of the organization might be deemed more cost effective than training employees and retraining individuals for positions, especially if there is a high turnover rate within the organization. It may also prove more cost effective to offer a health care plan supported by organizational wellness programs that promote positive healthy living and healthy eating, exercise, work life standards, smoking cessation, mental health, and even some alternative medicine. These benefits might not only raise the morale level of the company, but might, and more importantly, improve the health and well being of employees to the extent that the company has to spend less on hiring and training new employees. Managing an organization with high productivity and consistent products resulting from such a program would be a far better investment and less expensive to create and manage than health care insurance. The company would save by not having to spend as much money on medical care after the fact of an employee's illness that might have been prevented by participation in a wellness program.

Recommendations

The data from this study might be used in later research that allows for broader interpretation and adds perspective to health care policy design and organizational leadership planning. Results from this study might spark additional research of ways to improve organizational perceptions and understanding of health care policy design and benefit administration. The study might be repeated using different populations: employees within a single organization, a population within a particular industry, employees who belong to unions, in specific parts of the country, with employers only, with human resource officers only to learn specific perspectives of that population. The study might be conducted in 2014 after full implementation of the PPACA and again in 2017 after it has been in effect for 3 full years.

Instead of investigating the relation of the modifiers of age, gender, and job title, aspects such as ethnicity, demographics, and education level might be variables. However, I would strongly recommended carrying out another investigation using the same moderating variables of age, gender, and job title using a larger sample size to see if a correlation exists between those satisfied with health care benefits with an individual satisfied with their work or job after the full effects of the PPACA.

Another goal might be to learn the perspectives of employees on a larger scale and determine to what extent women are satisfied with both benefits and the job compared to a male counterpart. It would be interesting to learn if age influences the gender difference or if the job itself creates a greater difference in perspective. With a

larger sample size using different moderating variables, the implications for larger organizational planning may result in different decisions.

Other recommendations include investigating the views of those whose have the option of employer-provided benefits and prefer not to join the plan, as a qualitative study. The individual and organization can express any frustrations with the added cost to the individual who does not pay along with the employer who remains liable for the cost, regardless of whether the employee accepts the benefits. A study of this nature can provide an added perspective to case study as the approach, one that seeks the opinions and experiences from the organization or employees perspectives and provides statistical data as well as language.

A final recommendation is to investigate the scenario of smaller organizations not offering full benefits to determine employee job satisfaction and to learn what aspect of the job they would like to see changed. An investigation of this kind done as a mixed method study might disclose both a quantifiable interpretation of perspective along with a qualitative investigation with interviews to factor in the needs of employees and simplify use of benefits by providing the option of a cafeteria plan that allows employees to select the benefits they want. Employees with young children might choose orthodontic care, while older employees might prefer doctor visits and prescription costs. The findings from a mixed method study could add an updated quantitative analysis with interviews with participants to create a greater understanding and depth of analysis.

Conclusion

As PPACA 2010 is fully implemented in 2014, there will be new opportunities for future exploration of how health care benefits affect employee job satisfaction. Even though those changes are coming, the results of this study should illustrate to employers today that there is a clear connection between employee health care benefits and employee job satisfaction. The social change inherent in what the results illustrated may enable organizations to make better-informed decisions as they compare the cost and benefits of offering employee health insurance options at first hire weighed against employee satisfaction with their jobs, organizational forecasting, employee stability, and health care policy design.

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Appendix A: Employer-Provided Healthcare Care Satisfaction Survey

The following questions are about your level of satisfaction with different aspects of your employer-provided healthcare plan. Please answer each question to the best of your ability.

1. How satisfied are you with your health care benefit plan offered by your organization?

Very Dissatisfied Dissatisfied Neutral Satisfied Very Satisfied

2. How satisfied are you with the level of explanation or information provided to inform you of changes to your health care benefits plan offered?

Very Dissatisfied Dissatisfied Neutral Satisfied Very Satisfied

3. How satisfied are you with the set co-pay of your health care benefits plan?

Very Dissatisfied Dissatisfied Neutral Satisfied Very Satisfied

4. How satisfied are you with the options available in the health care benefits offered by your organization?

Very Dissatisfied Dissatisfied Neutral Satisfied Very Satisfied

5. How satisfied are you with the flexibility you have to make changes to your health care benefits as offered by your organization?

Very Dissatisfied Dissatisfied Neutral Satisfied Very Satisfied

6. How satisfied are you with the way your health care benefits suit the needs of you and/or your family?

Very Dissatisfied Dissatisfied Neutral Satisfied Very Satisfied

7. How satisfied are you with the way your organization leadership team factors and/or considers your individual needs when designing the health care benefits offered by your organization?

Very Dissatisfied Dissatisfied Neutral Satisfied Very Satisfied

8. How satisfied are you with the way information shared with you when changes or updates are being made in the health care benefit plan?

Very Dissatisfied Dissatisfied Neutral Satisfied Very Satisfied

9. How satisfied are you as an employee regarding your ability to participate in the design of your health care benefits plan provided by your organization?

Very Dissatisfied Dissatisfied Neutral Satisfied Very Satisfied

Appendix B: Jobs-in-General Survey

Think of your job as a whole. All in all, what is it like most of the time? In the blank beside each word or phrase below, write “Yes” if it describes your job or “No” if it does not describe it or you cannot decide.

10. _____ Pleasant
11. _____ Bad
12. _____ Great
13. _____ Waste of time
14. _____ Good
15. _____ Undesirable
16. _____ Worthwhile
17. _____ Worse than most
18. _____ Acceptable
19. _____ Superior
20. _____ Better than most
21. _____ Disagreeable
22. _____ Makes me content
23. _____ Inadequate
24. _____ Excellent
25. _____ Rotten
26. _____ Enjoyable
27. _____ Poor

Appendix C: Permission To Use Jobs-in-General Survey

Bowling Green State University

Job Descriptive Index (JDI) Office
214 Psychology Building Department of Psychology
Bowling Green State University
Bowling Green, OH 43403

April 26, 2012

The Job Descriptive Index (JDI) and family of measures – including the Job In General scale (JiG), abridged Job Descriptive Index (aJDI), abridged Job In General scale (aJiG), Trust in Management scale (TiM), Intent to Quit (ITQ), Stress in General (SiG) scale, and Survey of Work Values, Revised, Form U. (SWV*)* are owned by Bowling Green State University, copyright 1975-2012.

Permission is hereby granted to **Tanya Pyke** to use these measures in his or her research. The aforementioned scales may be administered as many times as needed in this course of this research.

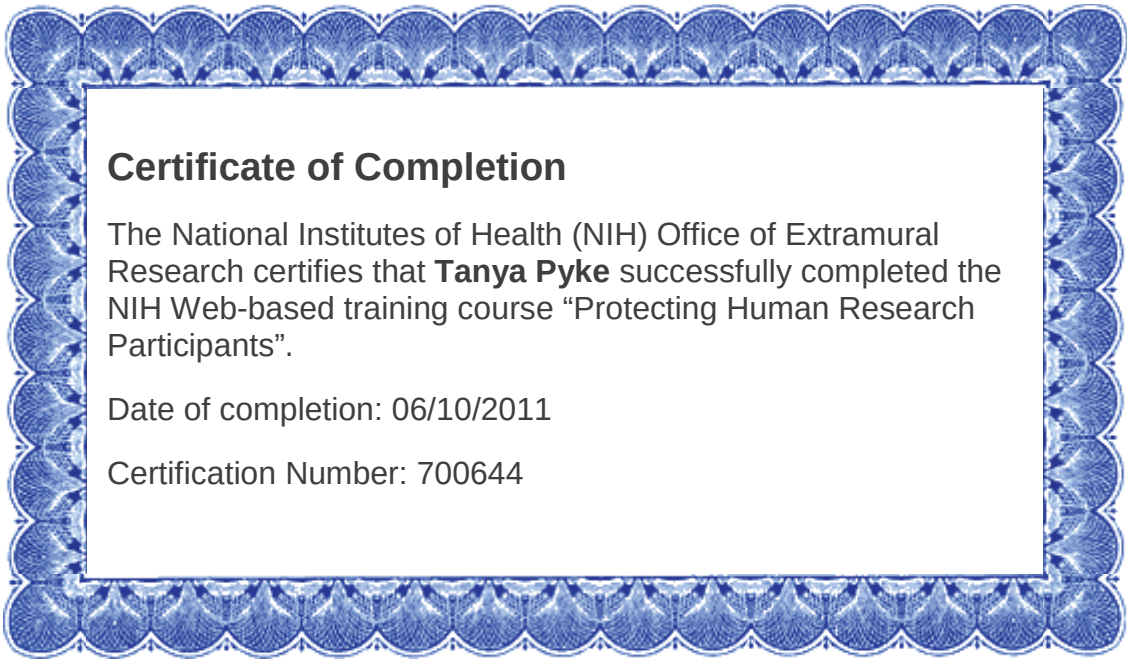
Chris Chang

Chris Chang
JDI Research Assistant
Tel: 419.372.8247
Fax: 419.372.6013 jdi_ra@bgsu.edu

Appendix D: Certificate of Completion

National Institutes of Health

According to Walden University, expires three years after date of completion.



Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Tanya Pyke** successfully completed the NIH Web-based training course “Protecting Human Research Participants”.

Date of completion: 06/10/2011

Certification Number: 700644

Appendix E: Department of Public Policy and Administration

Walden University

PARTICIPANT CONSENT FORM

You are invited to take part in a research study of the impact of Health Care Benefits on Job Satisfaction. The researcher is inviting any persons whom are employed full time (40hrs per week) and receiving health care benefits from said employer to be in the study. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part. Please set aside 7 to 10 minutes to complete this survey within the next few days to week.

This study is being conducted by a researcher named Tanya Pyke, who is a doctoral candidate completing her dissertation at Walden University.

Background Information:
The purpose of this study is to determine any relationship between Health Care Benefits packages and Job Satisfaction. Survey results will be used for this study only – Information obtained from this survey beyond this study will be deleted or destroyed.

Procedures:
If you agree to be in this study, you will be asked to:

- Complete a survey investigating your level of satisfaction with the health care benefits provided by your employer and the remaining questions measure key components of workplace or job satisfaction:
  - Employer-Provided Healthcare Plan Satisfaction Survey

Here are some sample questions:

- Employer-Provided Healthcare Plan Satisfaction Survey:
  - How satisfied are you with the level of explanation or information provided to inform you of changes to your health care benefits plan offered?

Very Dissatisfied Dissatisfied Neutral Satisfied Very Satisfied

Voluntary Nature of the Study:
This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one at Walden University will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind during or after the study. You may stop at any time.

Risks and Benefits of Being in the Study:
Being in this study would not pose risk to your safety or wellbeing. The participant will not encounter any risks that exceed those encountered in everyday life. The purpose of this study is to provide an updated assessment of the work place assessment of the Impact of Health Care Benefits on Job Satisfaction. The results of this study are intended to support collaborative decision making between employers and employees within the work place and the design of Health Care Benefits. The study is meant to benefit society and to support positive social change.

Payment:
There is no payment for participation.

Privacy:
Any information you provide will be kept anonymous. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept secure by an alpha-numeric code and used only in aggregate. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:
You may ask any questions you have now. Or if you have questions later, you may contact the researcher via Tanya.Pyke@waldenu.edu. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 1-800-925-3368, extension 1210. Walden University's approval number for this study is **10-24-12-0122744** and it expires on **October 13, 2013.**

Statement of Consent: _____

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. Please keep or print a copy of this consent form for your records. The research Tanya Pyke can be reached at Tanya.Pyke@waldenu.edu with any questions regarding this study. By clicking on the "Consent" icon, I agree to the terms of participation in this study.

Thank you for your response and time.

Appendix F: Frequency Tables for All Survey Questions

What is your gender?

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Female	92	60.9	60.9	60.9
	Male	58	38.4	38.4	99.3
	Prefer not to say	1	.7	.7	100
	Total	151	100.0	100.0	

What is your age?

		Frequency	Percent	Valid percent	Cumulative percent
Valid	18-24	5	3.3	3.3	3.3
	25-34	34	22.5	22.5	25.8
	35-44	48	31.8	31.8	57.6
	45-54	37	24.5	24.5	82.1
	55-64	20	13.2	13.2	95.4
	65-74	7	4.6	4.6	100.0
	Total	151	100.0	100.0	

What is your current job category?

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Employee	97	64.2	65.5	65.5
	Supervisor/Manager	29	19.2	19.6	85.1
	Director	19	12.6	12.8	98.0
	CEO/President	3	2.0	2.0	100.0
	Total	148	98.0	100.0	
Missing	System	3	2.0		
Total		151	100.0		

How satisfied are you with the health care benefit plan offered by your organization?

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Very dissatisfied	13	8.6	8.6	8.6
	Dissatisfied	22	14.6	14.6	23.2
	Neutral	35	23.2	23.2	46.4
	Satisfied	51	33.8	33.8	80.1
	Very satisfied	30	19.9	19.9	100.0
	Total	151	100.0	100.0	

How satisfied are you with the level of explanation or information provided to you of changes to your health care benefit plan?

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Very dissatisfied	9	6.0	6.0	6.0
	Dissatisfied	27	17.9	17.9	23.8
	Neutral	34	22.5	22.5	46.4
	Satisfied	55	36.4	36.4	82.8
	Very satisfied	26	17.2	17.2	100.0
	Total	151	100.0	100.0	

How satisfied are you with the co-pay set by your health care benefits plan?

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Very dissatisfied	12	7.9	7.9	7.9
	Dissatisfied	30	19.9	19.9	27.8
	Neutral	31	20.5	20.5	48.3
	Satisfied	61	40.4	40.4	88.7
	Very satisfied	17	11.3	11.3	100.0
	Total	151	100.0	100.0	

How satisfied are you with the options available in the health care benefits offered by your organization?

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Very dissatisfied	10	6.6	6.6	6.6
	Dissatisfied	30	19.9	19.9	26.5
	Neutral	37	24.5	24.5	51.0
	Satisfied	51	33.8	33.8	84.8
	Very satisfied	23	15.2	15.2	100.0
	Total	151	100.0	100.0	

How satisfied are you with the flexibility you have to make changes to your health care benefits as offered by your organization?

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Very dissatisfied	11	7.3	7.3	7.3
	Dissatisfied	44	29.1	29.1	36.4
	Neutral	45	29.8	29.8	66.2
	Satisfied	37	24.5	24.5	90.7
	Very satisfied	14	9.3	9.3	100.0
	Total	151	100.0	100.0	

How satisfied are you with the way your health care benefits suit the needs of yourself and/or your family?

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Very dissatisfied	12	7.9	7.9	7.9
	Dissatisfied	26	17.2	17.2	25.2
	Neutral	26	17.2	17.2	42.4
	Satisfied	59	39.1	39.1	81.5
	Very satisfied	28	18.5	18.5	100.0
	Total	151	100.0	100.0	

How satisfied are you with the way your organization leadership team factors and/or considers your individual needs when designing health care benefits for employees?

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Very dissatisfied	18	11.9	11.9	11.9
	Dissatisfied	40	26.5	26.5	38.4
	Neutral	44	29.1	29.1	67.5
	Satisfied	27	17.9	17.9	85.4
	Very satisfied	22	14.6	14.6	100.0
	Total	151	100.0	100.0	

How satisfied are you with the way information is shared with you when changes or updates are made in the health care benefit plan?

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Very dissatisfied	6	4.0	4.0	4.0
	Dissatisfied	32	21.2	21.2	25.2
	Neutral	32	21.2	21.2	46.4
	Satisfied	55	36.4	36.4	82.8
	Very satisfied	26	17.2	17.2	100.0
	Total	151	100.0	100.0	

How satisfied are you as an employee regarding your ability to participate in the design of your health care benefits plan provided by your organization?

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Very dissatisfied	31	20.5	20.5	20.5
	Dissatisfied	40	26.5	26.5	47.0
	Neutral	46	30.5	30.5	77.5
	Satisfied	24	15.9	15.9	93.4
	Very satisfied	10	6.6	6.6	100.0
	Total	151	100.0	100.0	

Pleasant

		Frequency	Percent	Valid percent	Cumulative percent
Valid	No	20	13.2	13.2	13.2
	?	6	4.0	4.0	17.2
	Yes	125	82.8	82.8	100.0
	Total	151	100.0	100.0	

Bad

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Yes	14	9.3	9.3	9.3
	?	8	5.3	5.3	14.6
	No	129	85.4	85.4	100.0
	Total	151	100.0	100.0	

Great

		Frequency	Percent	Valid percent	Cumulative percent
Valid	No	58	38.4	38.4	38.4
	?	18	11.9	11.9	50.3
	Yes	75	49.7	49.7	100.0
	Total	151	100.0	100.0	

Waste of time

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Yes	11	7.3	7.3	7.3
	?	3	2.0	2.0	9.3
	No	137	90.7	90.7	100.0
	Total	151	100.0	100.0	

Good

		Frequency	Percent	Valid percent	Cumulative percent
Valid	No	16	10.6	10.6	10.6
	?	4	2.6	2.6	13.2
	Yes	131	86.8	86.8	100.0
	Total	151	100.0	100.0	

Undesirable

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Yes	17	11.3	11.3	11.3
	?	4	2.6	2.6	13.9
	No	130	86.1	86.1	100.0
	Total	151	100.0	100.0	

Worthwhile

		Frequency	Percent	Valid percent	Cumulative percent
Valid	No	14	9.3	9.3	9.3
	?	7	4.6	4.6	13.9
	Yes	130	86.1	86.1	100.0
	Total	151	100.0	100.0	

Worse than most

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Yes	12	7.9	7.9	7.9
	?	9	6.0	6.0	13.9
	No	130	86.1	86.1	100.0
	Total	151	100.0	100.0	

Acceptable

		Frequency	Percent	Valid percent	Cumulative percent
Valid	No	11	7.3	7.3	7.3
	?	5	3.3	3.3	10.6
	Yes	135	89.4	89.4	100.0
	Total	151	100.0	100.0	

Superior

		Frequency	Percent	Valid percent	Cumulative percent
Valid	No	82	54.3	54.3	54.3
	?	12	7.9	7.9	62.3
	Yes	57	37.7	37.7	100.0
	Total	151	100.0	100.0	

Better than most

		Frequency	Percent	Valid percent	Cumulative percent
Valid	No	27	17.9	17.9	17.9
	?	7	4.6	4.6	22.5
	Yes	117	77.5	77.5	100.0
	Total	151	100.0	100.0	

Disagreeable

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Yes	17	11.3	11.3	11.3
	?	10	6.6	6.6	17.9
	No	124	82.1	82.1	100.0
	Total	151	100.0	100.0	

Makes me content

		Frequency	Percent	Valid percent	Cumulative percent
Valid	No	50	33.1	33.1	33.1
	?	11	7.3	7.3	40.4
	Yes	90	59.6	59.6	100.0
	Total	151	100.0	100.0	

Inadequate

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Yes	26	17.2	17.2	17.2
	?	5	3.3	3.3	20.5
	No	120	79.5	79.5	100.0
	Total	151	100.0	100.0	

Excellent

		Frequency	Percent	Valid percent	Cumulative percent
Valid	No	69	45.7	45.7	45.7
	?	16	10.6	10.6	56.3
	Yes	66	43.7	43.7	100.0
	Total	151	100.0	100.0	

Rotten

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Yes	9	6.0	6.0	6.0
	?	3	2.0	2.0	7.9
	No	139	92.1	92.1	100.0
	Total	151	100.0	100.0	

Enjoyable

		Frequency	Percent	Valid percent	Cumulative percent
Valid	No	32	21.2	21.2	21.2
	?	12	7.9	7.9	29.1
	Yes	107	70.9	70.9	100.0
	Total	151	100.0	100.0	

Poor

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Yes	14	9.3	9.3	9.3
	?	5	3.3	3.3	12.6
	No	132	87.4	87.4	100.0
	Total	151	100.0	100.0	

Curriculum Vitae

Tanya A. E. Chin-Pyke

Education

PhD Public Policy and Administration — Expected August 2013
Walden University, Minneapolis, MN
Pi Alpha Alpha National Honor Society

Pre-Law Program — Summer 1997
The University of Oxford, Oxford, UK

MPA Public Administration and Policy — December 1996
The University of Akron, Akron, Ohio
Research Assistant: Department of Graduate Studies
Internship: Akron Urban Minority Alcoholism Drug Abuse Outreach Program, Inc.
(Personnel Coordinator)

BS, Industrial Management — December 1994
The University of Akron, Akron, Ohio

Work History

Co-Owner — June 2008-present
AMP Hospitalist Consulting, LLC, Mountain Top, PA

Recruitment and Development — June 2001-December 2002
Saint Vincent Health System Professional, Erie, PA

Credit Analyst — April 1998 - December 1998
AllFirst / First Maryland Bankcorp, Harrisburg, PA

Customer Support Analyst — February 1997- February 1998
Cardinal Health, Inc., Dublin, OH

Research Analyst — January 1995--October 1995
Roadway Express, Akron, OH

Human Resources Assistant — January 1994- May 1994
REVCO D.S., Inc., Twinsburg, OH

Project Analyst, Senior Recruiter — March 1999- June 2001
TMP Worldwide e-Resourcing, Philadelphia, PA

Related Skills

Management

- Formulated recruiting budgetary needs.
- Responded to HR-related, hospital staff needs.
- Screened, interviewed, and reviewed necessary applications and start-up paperwork for candidate placements.
- Established compensation packages and pay rates for candidates.
- Managed/coordinated process for executive positions including hospital-wide interviews, all correspondence, relocation, and assimilation efforts.

Recruiting and Training

- Recruiter for professional, executive, and hard-to-fill positions.
- Updated and maintained job descriptions and weekly postings.
- Participated in rewriting employee manual/handbook including policy statements.
- Coordinated, administered, and implemented a nurses' aide training program.
- Participated in overall marketing and human resource strategic planning.
- Represented health center at job fairs, conventions, and seminars.
- Maintained a recruiting presence at the Tri-State area colleges.
- Worked with physician recruiting and community outreach programs.
- Recruit for both national and international projects.
- Coordinate and complete regional training sessions.
- Determined skill levels and devised career plans.
- Continually developed submittal profiles to clients to enhance quality of service.
- Initiate the completion of work appraisals and evaluations on a quarter, bi-annual as well as annual basis.

Problem Solving/Planning/Organization

- Participated in strategic planning for nurses and executive recruiting.
- Coordinated programs for various outreach programs.
- Resolved staffing concerns.

Administrative and Operational Management

- Worked with state legislators to increase funding toward improving salary and benefit options for specific health care positions.
- Participated in rolling out new HRIS software application (LAWSON).
- Prepared for Department of Health and other auditing body health inspections.
- Established and implementing agency and associate contract term/agreements.

Employee Relations

- Manage fluctuating volumes of contract associates.
- Maintain understanding of associates' daily responsibilities, challenges, and motivators.
- Establish innovative resources to identify new talent.
- Screen, interview, and complete all application and start-up paperwork for candidate placements.
- Establish compensation packages and pay rates for new assignments.
- Enforce consequences for contract violation.

- Coordinate and score annual performance appraisals.
- Participate in formulating and implementing client and associate contract agreements.

Problem Solving/Planning/Organization

- Consistent record of accomplishment of meeting company goals through demonstrated skills in critical thinking, methodical planning, thorough organization, and follow through.
- Maintain constant awareness of the bottom line, developing and deploying initiatives that generate revenue.

Communications and Team Collaboration

- Perform mock interviews and coordinate placements for graduating students.
- Strategically orchestrated multiple presentations at local technical institutes to promote flagship products and distinctive value added service.

Certifications and Licensures

Licensed Real Estate Agent, Coldwell Bankers, Erie, PA	2007-present
Notary Public, Practicing, State of Pennsylvania	2005- present
Senior Human Resource Professional Certification Coursework	2002

Community Service

American Red Cross, Wyoming Valley Chapter, Wilkes Barre, PA	October 2008- present
Veterans Hospital of Wilkes Barre, PA, Secured Alzheimer's Unit	March 2009-present
President, School Board, Montessori, Children's House of Erie, Erie, PA	June 2007 - July 2008

Professional Associations

American Society for Public Administration (ASPA), Member	1995- Present
Society of Human Resource Management (SHRM), Member	1993- Present
Chapter President and Treasurer	1992-1993

Honors and Activities

Leadership and Scholastic Excellence Award	1994
Summit County Children Services Board	
Mentoring (adolescent) Mother's Program – Counselor	1993- Present
Alpha Kappa Alpha Sorority, Inc.	1993 - Present
Chapter President	1993- 1994