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The Effects of Health Benefit Use on Organizational and Union Commitment among Full and Part-Time Retail Employees

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THE EFFECTS OF HEALTH BENEFIT USE AND
SATISFACTION ON COMMITMENT AMONG FULL
AND PART-TIME EMPLOYEES

A Thesis
Presented to
the Graduate School of
Clemson University

In Partial Fulfillment
of the Requirements for the Degree
Master of Science
Applied Psychology

by
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ABSTRACT

Previous research on employee benefits has found that benefits are related to various employee attitudes including job satisfaction, turnover intentions, organizational commitment, perceived organizational support, affective organizational commitment, and continuance organizational commitment (Blau et al., 2001; Sinclair, Leo, & Wright, 2005; Williams et al., 2002). The current study examined how health benefit use and health benefit satisfaction influence three types of commitment: affective organizational, continuance organizational and union loyalty. To date, researchers have never examined the differential effects of health benefits use in full and part-time employees. Given that it is uncommon for part-time employees to be offered benefits, part-time employees may view their benefits as a way in which the organization or union demonstrates that they care for their employees or members as individuals. Therefore, I hypothesized that employee work status would moderate the relationship between health benefit use and health benefit satisfaction on affective organizational commitment and union loyalty, such that those who use their benefits, are highly satisfied, and work part-time have the highest commitment levels. Results indicated that benefit satisfaction was a significant predictor of all study outcomes. However, benefit use only predicted continuance commitment. No support was found for any hypothesized interactions, however an unexpected interaction between benefit use and employee work status was found. Possible explanations for the findings are presented, followed by limitations of the study. Lastly, implications and suggestions for future research are discussed.

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CHAPTER ONE

The Effects of Health Benefit Use and Satisfaction on Commitment among Full and Part-Time Employees

Understanding how workers respond to their health benefits is very important for organizations. In 2011, the United States Bureau of Labor Statistics estimated that private industry spent an average of \$29.50 an hour in total compensation. However, the average employer spent \$8.11 per hour on employee benefits, which accounts of 29.2% of total compensation. Therefore, the average organization is contributing nearly 30% of compensation costs towards employee benefits, indicating that organizations have a huge financial stake in understanding how benefits affect their employees. Furthermore, an estimated 7.6% of total compensation costs were specifically related to employee health benefits. Researchers have demonstrated that benefits are related to various employee attitudes including job satisfaction, turnover intentions, organizational commitment, perceived organizational support, affective organizational commitment, and continuance organizational commitment (Blau et al., 2001; Sinclair, Leo, & Wright, 2005; Williams et al., 2002). These attitudes are in turn related to important organizational outcomes such as employee performance and turnover.

Purpose of the Current Study

The present study explored how health benefit satisfaction and health benefit use affect different forms of commitment in full and part-time employees. Much of the previous benefit literature has focused on predicting benefit satisfaction (Tsai & Wang, 2005), rather than examining the relevant outcomes of benefit-related variables.

Furthermore, much of the benefits literature has not taken into account variability in the extent to which employees utilize their health benefits. Therefore, I hypothesize that employees who both use and are satisfied with their health benefits are more likely to appreciate and value their benefits. I suggest that health benefit use, moderated by benefit satisfaction, will predict affective organizational commitment. This will extend the current literature on outcomes of benefit satisfaction and will also determine if benefit use is a valuable variable in determining employee commitment.

This study also examined how health benefit use and satisfaction are related to union loyalty, which is a major interest of unions. Union loyalty has been shown to be related to union participation, union citizenship behavior (Tan & Aryee, 2002), and members' willingness to strike (Martin & Sinclair, 2001). Unions play a critical role in negotiating benefit contracts for employees (Barling, Fullagar, & Kelloway, 1992), which could indicate to the union's members that the union values them as individuals. Therefore, I hypothesized that benefit use and satisfaction will also be positively related to union loyalty.

In addition, there is need to determine how the provision of health benefits affects part-time employees, as it is uncommon for part-time employees to be offered benefits. The tenants of social exchange theory propose that the relationship between and individual and a group are based upon a series of exchanges (Blau, 1964), and when these exchanges are viewed as more discretionary they should be more influential (Sinclair, Hannigan, & Tetrick, 1995). For these reasons, I theorize that health benefits will have a stronger effect on the commitment of part-time employees, who are more likely to view

benefits as a discretionary offering, than on full-time employees who are more likely to feel entitled to health benefits (Weathington & Tetrick, 2000). Therefore, the current study also examined how benefit satisfaction, benefit use, and the interaction between benefit use and satisfaction predicts company and union commitment in full and part-time employees.

In this study, I begin by reviewing the previous literature on employee benefits. This includes research related to benefit satisfaction, benefit use, and the antecedents and outcomes of these variables. Then, I overview research related to employee work status in terms of full and part-time employees. In the last section, I examine the outcome variables of affective organizational commitment, continuance organizational commitment, union loyalty, and provide rationale for my hypotheses.

Literature Review

Employee Benefits

Compensation satisfaction is a multidimensional construct that has been shown to be correlated with perceived organizational support, turnover intentions, and affective commitment (Williams et al., 2008). Benefit satisfaction is considered one of the factors of overall compensation satisfaction. Most of the compensation satisfaction literature uses the factors proposed by Heneman and Schwab (1985): satisfaction with current pay level, pay raises, benefit level, and pay structure and administration (Williams, McDaniel, & Ford, 2007). Benefit level refers to any compensation that the employee receives for time not worked, such as health insurance, life insurance, retirement plans, etc. (Heneman & Schwab, 1985). Benefit satisfaction is an important variable of interest

to organizations because the provision of benefits is a “significant expense to business and an essential tool for recruitment and retention” (Williams, Malos, & Palmer, 2002, p. 195). Consistent with this idea, Garcia and Posthuma (2010) found that job ads with detailed descriptions of benefits offered produced more applicant interest than ads lacking details on benefits. Furthermore, benefit satisfaction has been shown to be indirectly related to motivation and trust (Weathington & Jones, 2006).

Since the work of Heneman and Schwab (1985), benefit satisfaction has been further broken down into two factors: benefit level satisfaction and benefit system satisfaction (Miceli & Lane, 1991). Benefit level satisfaction refers to how satisfied individuals are with the amount or level of benefits they receive. Benefit system satisfaction refers to satisfaction with the system in which benefits are chosen and administered to employees.

Benefit level satisfaction has traditionally been measured as the discrepancy between the perceived amount of benefits that *should* be received and the perceived amount of *actual* benefits received (Balkin & Griffeth, 1993). The amount of benefits a person believes they should receive is determined by perceived personal job inputs, perceived job demands, and the perceived inputs and outcomes of referent others. For example, an hourly employee may feel entitled to the same health care plan as a salaried employee. Similarly, the perceived amount of benefits actually received is a function of actual benefits received, benefits history, and the perceived benefits of referent others (Balkin & Griffeth, 1993). For instance, some employees may not be fully aware of their maternity benefits because they have not needed to use them. Benefit satisfaction is

theoretically obtained when the perception of benefits that should be received and the perception of actual benefits received are equal. Likewise, benefit dissatisfaction occurs when the amount of benefits received is less than the amount of benefits an individual believes they should receive.

The majority of benefits-related research has focused on the antecedents and consequences of benefit satisfaction. Dreher, Ash, and Bretz (1988) determined that actual benefit coverage was more related to benefit satisfaction for individuals who had an accurate perception of their benefit coverage than those with inaccurate perceptions of their coverage. Moreover, benefit cost was negatively related to benefit satisfaction. Balkin and Griffeth (1993) found that pay level, female gender, and exempt status (salaried employees) all predict benefit satisfaction and that age and education level were negatively related to benefit satisfaction. Barber, Dunham, and Formisano (1992) determined that the implementation of a flexible benefits plan significantly increased benefit satisfaction and employee understanding of their benefit package. The role of flexible benefits plans in benefit satisfaction was further analyzed by Tremblay, Sire, and Pelchat (1998), who proposed that in order for benefit satisfaction to be increased, employee participation is not sufficient; the organization must also take into account suggestions made by employees.

Williams (1995) proposed a model of the antecedents and outcomes of benefit level satisfaction using the discrepancy definition of benefit satisfaction described above. Williams determined that benefit level satisfaction is most strongly predicted by benefit administration in the form of communication and employee input. Williams found a

negative relationship between employee cost for medical insurance and benefit satisfaction. Benefit comparison to referent others was also a significant predictor of benefit satisfaction. Employees who rated their coverage as better than their peers' coverage had higher benefit satisfaction. Furthermore, benefit level satisfaction was unrelated to the discrepancy between the perceived amount of benefits that *should* be received and the *actual* amount of benefits received, indicating that this is not an effective method of determining benefit level satisfaction.

Less research has been dedicated to determining the outcomes of benefit satisfaction. Williams et al. (2002) found that benefit level satisfaction is positively related to job satisfaction and negatively related to turnover intentions, and that benefit system satisfaction is related positively to global job satisfaction. Others have found that benefit satisfaction was positively related to organizational commitment (Blau et al., 2001; Ward & Davis, 1995). Conversely, Tremblay, Sire and Balkin (2000) predicted that benefit satisfaction would have a positive effect on job and organizational satisfaction, but the results were not significant. These findings highlight some of the potential contributions of further research on benefit satisfaction, but also underscore the idea that there are relatively few studies with inconsistent findings.

Other researchers have simply examined how the provision of benefits (i.e. being offered a benefit) affects employees and organizations. Sinclair, et al. (1995) examined the effects of benefit coverage on affective and continuance organizational commitment. They found that family-related benefits were associated with perceived organizational support and affective commitment, whereas health benefits were related to continuance

commitment. The authors posit that family-related benefits are related to affective commitment because they are viewed by employees as something the employer is not expected to provide, and are thus perceived as an investment into employee well-being. Alternatively, employees do generally expect employers to provide health benefits. Therefore, these benefits do not signify the employer's value for them, and thus do not have an effect on their affective commitment. Tsai and Wang (2005) examined the role of benefits on organizational productivity. They determined that benefits can improve firm productivity by attracting higher quality employees.

Others have examined the effects of benefit use, rather than benefit satisfaction or coverage. One explanation for the effects of benefit use is that use should enhance awareness of coverage levels and knowledge of benefits. For example, Williams (1995) noted that, "Individuals who made extensive use of their benefits indicated that they received more benefits or higher levels of benefits than did individuals who reported less extensive benefit use" (p. 1119). Muse, Harris, Giles, and Field (2008) determined that employee utilization of benefits is positively related to employees' perceptions of organizational support and affective commitment. The authors explained these results saying, "Benefits that are used satisfy employee needs and thus influence the employee-employer relationship by motivating these employees to reciprocate" (p. 187). Benefit use may also be influential because those who use their benefits may have greater need for them, due to illness or their children's needs for healthcare. In other words, people who frequently use their benefits may place greater value on them. Therefore, employees who have never or rarely used the benefits offered to them may not possess information

by which to assess their benefits. However, employees who have used their benefits several times, such as visiting a doctor or hospital, will be much more familiar with the benefits offered, the benefits system in place, and may value their benefits more than people that do not use their benefits. For these reasons, benefit use should predict employee attitudes above and beyond benefit satisfaction alone.

Sinclair, Leo, and Wright (2005) examined how benefit use predicted affective and continuance organizational commitment. The authors assumed that employees are most likely to use the benefits that help them meet their needs. Benefit use was divided into the three separate constructs: alternative benefit use which consisted of legal and education services, employee assistance benefits, and childcare reimbursement accounts; health benefit use; and traditional benefit use which consisted of vacation, sick leave, and pension plans. Both alternative and health benefit use were found to be positively related to affective commitment, and health benefits use was associated with higher continuance commitment. These results indicate that employees who use their health benefits report higher levels of commitment.

An important distinction to make is that the positive outcome associated with benefit use assumes that employees are satisfied with their benefit coverage. For example, employees who are very satisfied with their health benefits, regular use of the benefit would be a steady reminder of their satisfaction with benefits, thus boosting employee attitudes. However, the opposite is also likely to be true; employees who are unsatisfied with their health benefits would be consistently reminded of their dissatisfaction every time they use their benefits. Therefore, I suggest that benefit use

will determine the strength of the relationship and benefit satisfaction will determine the positive or negative direction of the relationship.

Employee Work Status

An important factor in determining the relationship between employee health benefits and employee attitudes that has been overlooked in previous literature is employee work status. There are approximately 28 million part-time employees in the United States, and about 6.5 million of those individuals receive health care benefits (BLS, 2010). This indicates that a huge number of part-time employees are being excluded from examination in the health benefits literature. On the other hand, in 2010 part-time workers were 74% less likely to be insured than full-time workers (BLS, 2010). More specifically, 86% of full-time employees had access to medical care, whereas only 24% of part-time employees had access to medical care. Therefore although there are many part-time employees that do receive health benefits, the majority do not.

Many researchers have speculated about the differences in attitudes between full and part-time employees. Katz and Kahn (1978) proposed the concept of partial inclusion, which suggests that there are many roles vying for employees' time and energy, and therefore individuals are only "partially" involved in their work roles (as cited in Martin & Sinclair, 2007). Two competing hypotheses that have grown from this concept are the involvement hypothesis and the exposure hypothesis. Miller and Terborg (1979) found that part-time employees had less job satisfaction than full time employees, suggesting an "involvement hypothesis" in which part-time employees have poorer attitudes than full-time employees because they are less involved in the organization and

receive fewer benefits. Alternatively, the “exposure hypothesis” suggests that part-time employees have better attitudes than full-time employees because they have less exposure to the negative aspects of the organization (Eberhardt & Shani, 1984).

Researchers have examined differences between full and part-time employees, but the results have been inconclusive. Thorsteinson (2003) performed a meta-analysis in order to clarify this inconsistent body of literature. The results indicated that there were actually no significant differences between full and part-time employees in job satisfaction, organizational commitment, and intention to leave. Thorsteinson did find that full-time employees are more involved in their jobs than part-time employees. He also determined that part-time workers who voluntarily work part-time have higher job satisfaction than employees involuntarily working part-time.

As previous literature has shown, there may be reasons to suspect differences between full and part-time employees. However, benefit research has primarily examined full time employees (Balkin & Griffeth, 1993; Williams, 1995; Williams et al., 2002), or has not clarified if full or part time employees were sampled (Sinclair et al., 2005). An exception to this is Weathington and Jones (2006) in which both full and part-time employees were sampled, but employee work status was not utilized as a variable of interest.

Differences between full and part-time employees may be particularly relevant when considering how health benefit use predicts organizational and union commitment. From a legal perspective, organizations are not required to offer health benefits. However, even though health benefits are not legally mandated, many employees expect

health benefits, particularly full-time employees. Weathington and Tetrick (2000) found that “right status,” or how entitled employees felt they were to a specific benefit, moderated the relationship between benefit satisfaction and organizational commitment such that as right status increased, the relationship between satisfaction and commitment became less positive.

Given that full-time employees expect to receive health benefits, it is unlikely that health benefits will have a strong effect on the employee attitudes of full-time employees. However, part-time employees probably do not expect to receive health benefits. Sinclair et al. (1995) note that, “...a benefit that an individual sees as something employers should or do offer may not influence perceptions of organizational support or commitment. On the other hand, benefits that are considered less commonplace and are viewed as more discretionary are hypothesized to be more strongly related to perceived organizational support and commitment” (p. 166). Therefore, the provision of health benefits is expected to be more influential in part-time employees than in full-time employees.

Commitment

This study examined how benefit use and satisfaction influence the affective organizational commitment, continuance organizational commitment, and union loyalty of employees. Meyer and Allen (1984) distinguished between affective commitment, continuance commitment, and normative commitment. Affective commitment is described as employees’ emotional bond to an organization. Employees who are affectively committed to an organization wish to remain with the company because they identify with the organization’s goals and values, and feel a strong sense of loyalty to the

organization. Continuance commitment describes the commitment employees have based on the perceived costs in leaving an organization. Employees who have a strong sense of continuance commitment wish to remain with an organization because the costs of leaving the organization are greater than the costs of remaining. Although affective commitment and continuance commitment are very different, they both should result in employee desire to remain within an organization. Lastly, normative commitment describes the obligation employees feel to remain with an organization. Although normative commitment is conceptually separate from affective commitment, high correlations between the two variables have been found (Meyer & Herscovich, 2001). For this reason, coupled with the fact that there is less research available pertaining to normative commitment, I have chosen to omit it from this study.

Increased commitment to the union is another possible outcome of benefit use and satisfaction. Unions are often a critical force in obtaining and negotiating health benefits for employees, so it is logical that union commitment could result from benefit use. Union commitment is also an important variable to consider due to its strong relationship with union participation (Tan & Aryee, 2002). Furthermore, union loyalty has been shown to be a strong predictor of union members' willingness to strike, which is thought to give unions more leverage in contract negotiations (Martin & Sinclair, 2001).

The primary theoretical framework that will be used in this paper to explain why health benefits may influence various types of commitment is social exchange theory. Social exchange theory suggests that in order to form meaningful relationships, certain 'exchanges' between employer and employee must take place (Cropanzano & Mitchell,

2005). These exchanges are guided by the reciprocity rule in which the actions of one party are dependent on the actions of the other. In relation to employee benefits, employees should be more satisfied and committed to employers if they are provided with, and satisfied by, their benefits (Dulebohn, Molloy, Pichler, & Murray, 2009).

Dreher et al. (1988) note that:

The central argument is that by fulfilling basic economic, security, and social needs, improved benefit coverage increased employee satisfaction, loyalty, and commitment. It is through these affective states that benefit program characteristics are assumed to influence important behavioral outcomes such as voluntary turnover and absenteeism. (p. 238)

Exchange situations can be symbolized on a continuum from purely social to purely economic (Blau, 1974). Social and economic exchanges are thought to operate differently in that social exchange fosters affective commitment from employees and economic exchange fosters continuance commitment (Blau, 1964; Tetrick, 1995). The importance of social exchanges in promoting affective commitment is evidenced by the work of Naumann, Bennet, Bies, and Martin (1998) who examined employees who had been laid off at a major manufacturing plant. The authors found that perceptions of organizational support partially mediated the relationship between interactional justice and organization commitment. They suggested that "...those managers that establish a history of organizational support through showing employees that their contributions are valued and communicating to employees that the organization is committed to them will enjoy greater organizational commitment, in turn, from employees" (p. 364).

The provision of benefits to an employee is a unique transaction in that it does not easily fall under the categories of either social or economic exchange. Rather, I would argue that the provision of health benefits has both social and economic properties. The economic properties of the provision of benefits are, perhaps, the easiest to identify in the direct costs they pose to the company and to the employees. In contrast to the economic properties of health benefits, it is important to note that health benefits have value beyond their monetary worth. Many employees are likely to greatly value their health benefits above and beyond what they or the company pays for the benefits. Health benefits may provide peace of mind in that employees know that if they or their children or spouse become ill or injured, they will have means to remedy the situation. Therefore, the provision of health benefits could also be interpreted as a sign that the union or company cares about the well-being of employees.

Affective commitment. Affective commitment is the employees' desire to remain with an organization. Affective commitment is an important variable because it has been shown to be related to a wide variety of organizational and individual outcomes. Meyer, Herscovitch, and Topolnytsky (2002) meta-analyzed the relationship between affective commitment and its theoretical antecedents, correlates, and consequences. With regard to the antecedents of affective commitment, the authors found that affective commitment was negatively related to an external locus of control ($\rho = -.29$), role ambiguity ($\rho = -.39$), and role conflict ($\rho = -.30$). Affective commitment was positively related to organizational support ($\rho = .63$), transformational leadership ($\rho = .46$), interactional justice ($\rho = .50$), distributive justice ($\rho = .40$), and procedural justice ($\rho = .38$).

When examining the correlates of affective commitment, the authors determined that affective commitment was correlated with job involvement ($\rho = .53$), occupational commitment ($\rho = .51$), and overall job satisfaction ($\rho = .65$). Lastly, the consequences of affective commitment were examined. Affective commitment was negatively related to turnover ($\rho = -.17$) and withdrawal cognitions ($\rho = -.56$), and was positively related to overall job performance ($\rho = .16$). This study demonstrates that affective commitment is related to a number of important organizational variables, suggesting that organizations need to be aware of how organizational policies influence affective commitment in employees.

Researchers have suggested that one way in which employees reciprocate good treatment from organizations is through affective commitment (Cropanzano & Mitchell, 2005; Meyer & Allen, 1996; Rhoades, Eisenberger, & Armeli, 2001). In turn, organizations can demonstrate good treatment by providing health benefits. Consistent with previous literature (Blau et al., 2001; Ward & Davis, 1995), I predict that benefit satisfaction will be positively related to affective organizational commitment. Benefit use is also predicted to have a positive relationship with affective organizational commitment because those who frequently use their health benefits are likely to value their benefits more than those who infrequently use their benefits. Furthermore, I also predict an interaction between health benefit satisfaction and health benefit use such that those who are high on both variables will have the highest level of affective organizational commitment.

Hypothesis 1a: Health benefit satisfaction will be positively related to affective commitment.

Hypothesis 1b: Health benefit use will be positively related to affective commitment.

Hypothesis 1c: Health benefit use will moderate the relationship between health benefit satisfaction and affective commitment.

It is also likely that differences will be observed between full and part-time employees because full-time employees are more likely to view the provision of benefits as part of an economic exchange, rather than a social exchange. Conversely, part-time employees are likely to view health benefits as a discretionary offering and as a sign of support and value from the organization. Therefore, health benefits can be thought of as part of both a social and economic exchange for part-time employees. For these reasons, I predict that health benefit satisfaction, benefit use, and the interaction between benefit satisfaction and use will be more pronounced in part-time employees than in full-time employees (see Figure 1).

Hypothesis 1d: There will be a three way interaction between health benefit use, health benefit satisfaction, and employee work status on affective organizational commitment. More specifically, work status will moderate the relationship between health benefit use and satisfaction on affective commitment, such that such that the proposed interaction

between health benefit use and satisfaction on affective commitment will be stronger for part-time employees.

Continuance commitment. Continuance commitment is described as an employee's need to remain with an organization. Continuance commitment was originally conceptualized by Becker (1960) who theorized that commitment resulted from making "side bets" into the organization. Generally, a side bet refers to anything of value (e.g., effort, tenure, money) that would be lost if an employee were to leave the organization. Meyer and Allen (1984) note that, "the perceived cost of leaving may be exacerbated by a perceived lack of alternatives to replace or make up for the forgone investments" (p. 373). Therefore, continuance commitment can be theoretically conceptualized into two aspects: perceived sacrifice and perceptions of available alternatives (Meyer et al., 2002). Although some evidence suggests employees may distinguish these two aspects of continuance commitment (Meyer et al., 2002), researchers generally do not distinguish between the two in practice. Therefore, this study treats continuance commitment as a unidimensional concept.

Meyer et al. (2002) also meta-analyzed the relationships between continuance commitment and its theoretical antecedents, correlates, and consequences. Unlike affective commitment, Meyer et al. theorized that continuance commitment should be unrelated, or negatively related to positive work behaviors and outcomes. This is further explained by Meyer and Allen (1991), who note that those with "a high level of continuance commitment may exert considerable effort on behalf of the organization if they believe continued employment requires such performance. Where employment is

essentially guaranteed (i.e., is contingent only on exceeding some minimal standard) ...performance may be barely acceptable” (p. 77).

In the Meyer et al. (2002) meta-analysis, the significant antecedents of continuance commitment included organizational tenure ($\rho = .21$), organizational support ($\rho = -.11$), transformational leadership ($\rho = -.14$), role ambiguity ($\rho = .10$), role conflict ($\rho = .13$), interactional justice ($\rho = -.16$), distributive justice ($\rho = -.06$), procedural justice ($\rho = -.14$), transferability of education ($\rho = -.22$), and transferability of skills ($\rho = -.31$). The only significant correlates of continuance commitment examined was overall job satisfaction ($\rho = -.07$). The significant consequences of continuance commitment were overall withdrawal cognition ($\rho = -.18$), turnover intentions ($\rho = -.17$), absences ($\rho = .06$), and job performance ($\rho = -.07$). This meta-analysis demonstrates that continuance commitment is often negatively related to desirable constructs; however most of the relationships are relatively small.

If an individual quits his or her job, losing health benefits is likely to be viewed as a sacrifice. Benefit use will be positively related to continuance commitment and “sunk costs” because those who use their benefits the most should have a higher perceived loss than those who do not use their benefits. Therefore, I suggest that benefit use will be related to the continuance commitment of both full and part-time employees. In addition, part-time employees probably have fewer perceived alternatives than full-time employees given the uniqueness of offering health benefits to part-time employees. This leads me to predict that health benefit use will have a stronger effect on the continuance commitment of part-time employees than full-time employees.

Hypothesis 2a: Health benefit use will be positively related to continuance commitment.

Hypothesis 2b: The relationship between health benefit use and continuance commitment will be stronger in part-time employees than in full-time employees.

Union Loyalty. Gordon et al. (1980) describes union commitment as loyalty to the union, willingness to work for the union, responsibility to the union, and belief in unionism. He found that these constructs were highly correlated, but researchers maintain that they are distinct from one another (Shore, Tetrick, Sinclair, & Newton, 1994). The present study will focus on the union loyalty aspect of union commitment, as it is the most conceptually similar to affective organizational commitment.

Multiple models of the antecedents and consequences of union commitment have been theorized and tested. Bamberger, Kluger, and Suchard (1999) examined the models of Barling, Fullagar, and Kelloway (1992), Newton and Shore (1992), and Iverson and Kuruvilla (1995). Bamberger et al. (1999) point out that all three models examined include the common antecedents of organizational commitment, job satisfaction, prounion attitudes, and union instrumentality perceptions, as well as the common outcome of union participation. The authors note that the difference between union instrumentality and prounion attitudes is that union instrumentality measures the perceived impact that the union can have on obtaining desirable working conditions (i.e., scheduling, wages, benefits), whereas union attitudes represent overall perceptions towards the union.

The model proposed by Barling, et al. (1992) hypothesizes that each antecedent has an independent and direct effect on union commitment (Figure 2a). The second model examined (Newton & Shore, 1992), also hypothesized the direct effects of organizational commitment and job satisfaction on union commitment, but suggested that union instrumentality perceptions are fully mediated by pronunion attitudes (Figure 2b). Lastly, Iverson and Kuruvilla (1995) suggested that union instrumentality perceptions and pronunion attitudes both have direct effects on union commitment, and that job satisfaction is fully mediated by organizational commitment in predicting union commitment (Figure 2c).

In order to examine these three models, Bamberger et al. (1999) first meta-analyzed each of the relationships presented in the aforementioned models to determine estimates of the true effects. The results indicated that the relationship between each antecedent and union commitment were as follows: job satisfaction, ($\rho = .08$); pronunion attitudes ($\rho = .68$); union instrumentality perceptions ($\rho = .59$); organizational commitment ($\rho = .36$). The authors then used the values obtained from the meta-analysis to create a correlation matrix among the six variables being examined, which was then used to perform path analysis on the models being tested. The authors determined that an integrative model yielded the best fit to the data (Figure 1d) above and beyond the other models examined.

The work of Bamberger et al. (1999) was expanded upon by Tan and Aryee (2002), who used primary data rather than meta-analytically derived data. The authors extended the work of Bamberger et al. by including union socialization, the process by

which individuals gain the social knowledge to undertake a role within the union, as an antecedent of union commitment. Additionally, the dimensions of union citizenship behavior were included as an outcome of union commitment (opposed to union participation). The results supported that the integrative model proposed by Bamberger et al., in which union instrumentality, union socialization, and job satisfaction have both direct and indirect influences on union commitment, is the best fit to the data.

Given that union instrumentality is such a broad predictor of union loyalty, Morrow and McElroy (2006) sought to further analyze its effects. The authors divided union instrumentality into the union's ability to handle outcome-based concerns and process-based concerns. The outcome-based concerns examined were satisfaction with pay, satisfaction with the amount of time spent away from home, and satisfaction with safety climate. The process-based concerns examined were grievance system effectiveness and communication from national union leadership. Process-based concerns were found to be a significant predictor of union loyalty; however outcome-based concerns did not significantly predict union loyalty. This indicates that the economic exchange (outcome-based concerns) aspect of union instrumentality did not influence union loyalty in this sample. The results of Morrow and McElroy (2006) fall in line with the tenants of social exchange theory in that individuals must perceive the provision of benefits as part of a social exchange, rather than a purely economic exchange, in order for union loyalty to be increased.

It is also important to understand how exchange relationships between the organization and the union differ. Tetrick (1995) notes that the exchange relationship

between the employee and the employer is different than that of the employee and the union in that, “An individual is paid by the employer in exchange for his/her efforts while an individual pays the union in exchange for the provision of certain goods and services” (p. 583). Tetrick goes on to theorize that there is a tendency for individuals to initially consider their exchange relationship with the employer as social and to consider their exchange with the union as economic, which does not encourage affective commitment (Blau, 1964).

One aspect of union instrumentality that has not been examined in the previous literature is the moderating effects of benefits use on benefit satisfaction in the prediction of union commitment. In most cases the union is an instrumental force in obtaining and negotiating employee health benefits. Sinclair et al. (1995) point out that “winning benefits for the membership through collective bargaining could signal to the unions’ members that the union values them as individuals” (p. 167). Therefore, it is reasonable to suggest that employees may also attribute their health benefit coverage to efforts made by the union on behalf of members.

As predicted previously, benefit satisfaction should influence the direction of the relationship and benefit use should predict the strength of the relationship. In addition to the two main effects, I propose that union loyalty will be predicted by the interaction between benefit satisfaction and benefit use, such that benefit satisfaction predicts the direction of the relationship and benefits use predicts the strength of the relationship. Furthermore, full-time employees are more likely to view the provision of benefits as part of an economic exchange (Weathington & Tetrick, 2000). On the other hand, part-time

employees may view the provision of benefits from the union as more of a social exchange, as part-time employees are expected to view the offering of health benefits as more discretionary than full-time employees. Therefore, it is likely that the relationship between benefit use and benefit satisfaction will be a better predictor of union loyalty in part-time employees than in full-time employees.

Hypothesis 3a: Health benefit satisfaction will be positively related to union loyalty.

Hypothesis 3b: Health benefit use will be positively related to union loyalty.

Hypothesis 3c: Health benefit use will moderate the relationship between health benefit satisfaction and affective commitment.

Hypothesis 3d: There will be a three way interaction between health benefit use, health benefit satisfaction and employee work status on union loyalty. More specifically, work status will moderate the suggested interaction between health benefit use and satisfaction on union loyalty, such that proposed interaction between health benefit use and satisfaction will be stronger for part-time employees.

CHAPTER TWO

Method

Participants and Design

Data were previously collected as part of a larger survey given to union members. Respondents included 2,457 unionized retail employees at a large grocery retailer in the Midwest. Of those that responded, only employees who had been enrolled in the health benefits program through the union contract for 1 year were included in the analyses (N= 1,962) because the benefit use measure refers to use within the prior year. Of participants included in the analyses, 37.7% were male, and 62.3% were female; 22.4% were part-time employees and 77.4% were full-time employees; the average age of participants was 49 years old.

Measures

All scales used can be found in Appendix A.

Health benefit use was measured using two items: “In the last 12 months, how many times did you or your dependents go to the emergency room to get care” and “In the last 12 months, how many times did you or your dependents go to a doctor’s office or clinic (not counting the emergency) room to get care?” Benefit use is a formative measure as the above items do not seek to determine levels of an underlying construct, but are designed to measure instances of specific behaviors. Answers to each of these items were summed to form an overall measure of health benefit use.

Health benefit satisfaction was measured using seven items developed in collaboration with union officials for the purpose of the larger original study. Items

assess satisfaction with quality of medical insurance, vision benefits, dental benefits, prescription benefits, prepaid wellness benefits, available in-network medical providers, and quality of care received. Item responses were on a scale from very dissatisfied (1) to very satisfied (5) or not applicable (6). Cronbach's alpha for this scale was .93.

Responses indicating "not applicable" were coded as missing. A mean of item responses was used to form this measure.

An exploratory factor analysis was used to determine how many underlying factors exist within the benefit satisfaction measure. Results of this analysis revealed that one factor can be extracted from the data. Two criteria were used to come to this conclusion. This first is a general rule of thumb known as Kaiser's rule, which states that only those factors with an eigenvalue of one or more should be retained. The eigenvalue of the first factor extracted is 4.8, while all others are less than one. The second method, a scree plot (Figure 3), revealed that the majority of the variance is accounted for by one factor. Therefore, I concluded that the benefit satisfaction measure is best represented by a one-factor model.

Affective organizational commitment was measured using three items from Martin and Peterson (1987). A sample item is, "I am proud to tell others that I am part of the organization." Cronbach's alpha for this scale was .89. Continuance organizational commitment was measured using four items. Sample items included, "I have too much at stake to change jobs right now" and "I dread the thought of what might happen if I quit my job without having another lined up." Response options for both scales ranged from strongly disagree (1) to strongly agree (5). Cronbach's alpha for this scale was .83.

Union loyalty was measured using 3 items from Martin and Peterson (1987). An example item is “My values and the Union’s values are very similar.” Response options ranged from strongly disagree (1) to strongly agree (5). Cronbach’s alpha for this scale was .86.

Next, confirmatory factor analyses were performed to confirm the hypothesized factor structure of each measure. It is hypothesized that each measure is a unidimensional construct. Mardia’s normalized estimate, which is interpreted as a z-score, exceeded the recommended value of ± 5.0 (estimate = 10.54; Bentler, 2005, as cited in Byrne, 2006) for each measure. Therefore, robust estimates and fit indices were used because they are valid despite the violation of normality. Model fit refers to the specified model’s ability to reproduce the data. Fit indices used included the Comparative Fit Index (*CFI*), the Root Mean Square Residual Error of Approximation (*RMSEA*), and the Standardized Root Mean Square Residual (*SRMR*). A generally acceptable score for the *RMSEA* is less than .08; an acceptable score for the *CFI* is greater than .90; and a generally acceptable score of the *SRMR* is less than .10. A confirmatory factor analysis of affective commitment, continuance commitment, and union loyalty had acceptable fit (see Table 1). Factor loadings for the continuance commitment measure ranged from .68 to .84. Factor loading for affective commitment ranged from .77 to .90. Factor loadings for the union loyalty measure ranged from .75 to .93.

CHAPTER THREE

Results

Prior to analyses, the data were screened for univariate and multivariate outliers. One outlier was found, using Mahalanobis distance, to have undue leverage and was deleted from the data.

To test the assumption of homoscedasticity, Levene's test was used to determine if the variance in scores between full and part-time employees was generally equal. If Levene's test is significant, the variances between the two groups are concluded to be significantly different, suggesting heteroscedasticity. Levene's test did not reveal significant differences in the variance between full and part-time employees when predicting affective commitment or union loyalty. Levene's test revealed that there were significant differences in the variance between full and part-time employees when predicting continuance commitment. However, because the sample size is so large small differences between the groups can produce a significant Levene's test. Therefore, Levene's test was double checked using Hartley's F_{\max} , which is simply a ratio of the variances of the two groups (Field, 2010). The ratio of variances for part-time employees (variance = .752) to full-time employees (variance = .688) is 1.093, which exceeds the critical value of 1, indicating that the variances between full and part-time employees are different. It should be noted that with large sample sizes, any variance not equal to 1 exceeds Hartley's F_{\max} critical value (see Appendix B for critical values). However, other researchers have suggested that heteroscedasticity does not have undue influence at values less than 2 (Seber & Lee, 2003 as Cited in Rosopa, Schaffer, & Schroeder, 2012)

or 1.5 (DeShon & Alexander, 1996). Therefore, I concluded that given the small variance ratio and the large sample size and used in the current study it is unlikely that heteroscedasticity will have undue influence in this sample.

In all other study variables, the unstandardized residuals were plotted against the unstandardized predicted values. These scatter plots were used to graphically check for violations of the assumption of homoscedasticity. All scatter plots revealed residuals that were relatively constant across all levels of predicted values, indicating that homoscedasticity can be assumed. The assumption of normality was examined using q-q plots, which all indicated that the data is relatively normal.

Three control variables were used: age, gender, and number of children. Each of these variables has been shown to be related to how often individuals use their benefits. For example, the elderly and the very young are the more likely to use health services than middle-aged individuals (Straub, 2002). Young children use health services more than the general population because they are at an increased risk for illness as their immune systems are still developing. Similarly, there is increase in age-related diseases as people grow older. Gender was also used as a control variable because women report more symptoms and utilize health services more frequently than men (Baum & Grunberg, 1991; Fuller, Edwards, Sermsri, Vorakitphokatorn, 1993). Lastly, the number of children the employee has was used as a control variable because the benefit use variable asks about benefit use by dependents and employees. Those with children are expected to use health benefits more than those without children.

The means, standard deviations, and correlations between study variables are presented in Table 2. As mentioned in the method section, study variables were measured using a five-point scale. The mean scores for affective commitment ($M = 3.40$, $SD = .92$), union loyalty ($M = 3.42$, $SD = .89$), and benefit satisfaction scales ($M = 3.60$, $SD = .81$) were all past the midpoint of the scale and had standard deviations less than one. The mean score for continuance commitment was slightly higher than the other variables ($M = 4.09$, $SD = .84$). Benefit use had a much higher standard deviation than the other variables ($M = 7.35$, $SD = 4.10$). A greater degree of variance is to be expected with the benefit use measure as it is formative and there are no limits on the number of times an employee could use their health benefits, therefore the range of possible responses is much larger for health benefit use than the other measures examined. Correlational analyses revealed that benefit use was not significantly related to any of the study variables except for continuance commitment. Benefit satisfaction, however, was significantly related to all study dependent variables, with the strongest relationship being between affective commitment ($r = .28$).

Moderated multiple regression was used to test all study hypotheses. In order to minimize multicollinearity problems, the continuous variables health benefit use and health benefit satisfaction were mean centered. Employee work status, as indicated by union records, was dummy-coded such that full time employees were given a value of 1 and part-time employees were given a value of 0.

The first set of hypotheses posited that health benefit satisfaction and health benefit use would both be positively related to affective commitment (1a and 1b,

respectively), that there will be interaction between health benefit use and health benefit satisfaction (1c), and that there would be a three-way interaction between health benefit use, health benefit satisfaction, and employee work status (1d). These hypotheses were tested by entering the control variables into step 1 of the regression, health benefit satisfaction, health benefit use, and employee work status into step 2, the product terms between health benefit use and health benefit satisfaction, health benefit use and employee work status, and health benefit satisfaction and employee work status into step 3, and the product term between health benefit use, health benefit satisfaction, and employee work status into step 4.

Support for hypothesis 1a was found; health benefit satisfaction predicted affective commitment, $t(1831) = 12.40, p < .01$. Health benefit use did not predict affective commitment $t(1831) = -1.41, p = .16$, and no interaction between health benefit satisfaction and health benefit use was found, $t(1831) = .12, p = .91$. Furthermore, the interaction between employee work status, health benefit use, and health benefit satisfaction was not significant, $t(1831) = .66, p = .51$, suggesting that there is no support for hypothesis 1d. All regression results for hypotheses 1a – 1d can be seen in Table 3.

Although little support for hypothesis 1 was found, an unexpected interaction between employee work status and benefit use was found (Figure 4). This interaction suggests that as part-time employees use their benefits more, their affective commitment slightly increases. Specifically, as benefit use increases by 1 unit, affective commitment increases by .015 units. Conversely, as full-time employees use their benefits more, affective commitment slightly decreases; as benefit use increases by 1 unit, affective

commitment decreases by .013 units. The unique variance (sr^2) accounted for by this interaction is .0001, indicating that this is a very small effect.

The second set of hypotheses suggested that benefit use would be positively related to continuance commitment (2a) and that there would be an interaction between health benefit use and employee work status such that the relationship between health benefit use and continuance commitment would be stronger in part-time employees (2b). Hypothesis 2 was tested by entering the control variables into step 1 of the regression, health benefit use in step 2, and the product term between health benefit use and employee work status in step 3.

Results of the regression analysis indicated that benefit use is positively related to continuance commitment, $t(1829) = 3.50, p < .01, B = .02$. The interaction between benefit use and employee work status was not significant, indicating that hypothesis 2b was not supported, $t(1829) = -.49, p = .62, B = -.01$. Although not specifically hypothesized, main effects were found for both employee work status and health benefit satisfaction. Results indicated that benefit satisfaction was positively and significantly related to continuance commitment $t(1829) = 4.25, p < .01, B = .10$. Furthermore, full time employees ($M = 4.15, SD = .83$) reported significantly higher continuance commitment scores than part-time employees ($M = 3.91, SD = .87$). Cohen's d was calculated in order to determine the magnitude of this effect, $d = .17$, which is considered to be a small effect.

Similarly to the first set of hypotheses 1, the third set of hypotheses posited that health benefit satisfaction and health benefit use would both be positively related to union

loyalty (3a and 3b, respectively), that there would be an interaction between health benefit use and health benefit satisfaction (3c), and that there would be a three-way interaction between health benefit use, health benefit satisfaction, and employee work status (3d). Hypothesis 3 was tested by entering the control variables into step 1 of the regression, health benefit satisfaction, health benefit use, and employee work status into step 2, the product terms between health benefit use and health benefit satisfaction, health benefit use and employee work status, and health benefit satisfaction and employee work status into step 3, and the product term between health benefit use, health benefit satisfaction, and employee work status into step 4.

Results of the regression analysis indicate that benefit satisfaction is positively related to union loyalty, $t(1830) = 9.26, p < .01, B = .23$, providing support for hypothesis 3a. However, support was not found for hypothesis 3b as benefit use did not predict union loyalty, $t(1830) = .69, p = .49, B = .00$. A significant difference in union loyalty was found between full ($M = 3.45, SD = .89$) and part-time ($M = 3.29, SD = .91$) employees. Again, Cohen's d was calculated in order to determine the magnitude of this effect, $d = .27$, which is considered to be a small effect.

Support was not found for hypothesis 3c as the interaction between benefit satisfaction and benefit use was not significant, $t(1830) = -.82, p = .41, B = -.02$. In addition, support was not found for hypothesis 3d as the interaction between benefit satisfaction, benefit use, and employee work status did not reach the level of significance, $t(1830) = 1.22, p = .22, B = .06$.

CHAPTER FOUR

Discussion

This study sought to address several gaps in the benefits literature. First, this study tested how health benefit use and health benefit satisfaction predicted affective organizational commitment, continuance organizational commitment and union loyalty in full and part-time, retail employees. Three sets of hypotheses regarding the nature and direction of the relationships between the study variables were proposed. Although there was considerable evidence in the literature for the proposed hypotheses, little support was found in the data. The results of each study hypothesis, limitations of the present study, suggested directions for future research, and implications will be discussed.

Discussion of Findings

Hypotheses 1a-d. The first objective of the present paper was to determine the relationship between health benefit satisfaction and health benefit use on affective commitment in full and part-time employees. Previous research has found that benefit satisfaction is related to affective commitment (Blau et al., 2001; Ward & Davis, 1995). The relationship between benefit satisfaction and affective commitment is thought to work through the mechanisms of social exchange theory, such that the organization offers benefits that satisfy employees, who then reciprocate affective commitment to the organization. Results of the present study were consistent with previous research; benefit satisfaction was significantly related to affective organizational commitment (hypothesis 1a). Benefit use was also predicted to have a positive relationship with affective commitment (hypothesis 1b) because those who frequently use their health benefits are

likely to value their benefits more than those who do not frequently use their benefits. The direct test of this hypothesis indicated that benefit use is not significantly related to affective commitment.

In addition to the examination of benefit satisfaction and benefit use as main effects, an interaction between benefit use and satisfaction was also hypothesized (1c). The logic behind this prediction was that the frequent use of health benefits would enhance the effects of benefit satisfaction on employee attitudes. However, there was not empirical support for this relationship. One reason that the interaction between satisfaction and use may not have been significant is that there are a number of other variables that could influence this relationship. For example, frequent use of health benefits may be correlated with significant stressors, such as chronic illness or a sick child. These stressors may lead to a reduction or limitation of resources (Hobfoll, 1989), potentially influencing the individual to reallocate remaining resources to the most important areas of demand. In this hypothetical situation, it is unlikely that health benefit use and satisfaction would remain proximal predictors of affective commitment. In other words, health benefits may become less important when significant stressors, or other variables, are faced.

Lastly, I hypothesized that there would be an interaction between benefit satisfaction, benefit use, and employee work status (full or part-time). Work status is a previously overlooked variable in the benefits literature that is important to consider. Most full-time employees expect to receive health benefits from their employer (Weathington & Tetrick, 2000). Conversely, because it is a relatively uncommon for

employers to provide part-time employees with health benefits most part-time employees probably do not expect to receive them. For these reasons, I hypothesized that the interaction between benefit satisfaction and use would be more pronounced in part-time employees (see Figure 1), as they may be more likely to view their benefits as a discretionary offering made by the organization. However, results of the multiple regression analysis did not support this hypothesis.

Although there was not support for hypothesis 1b-d, there was some evidence to suggest that health benefits differentially influence full and part-time employees. Employee work status was found to moderate the relationship between health benefit use and affective commitment (Figure 3). Results indicated that there is a small, positive relationship between benefit use and affective commitment in part-time employees, which suggests that as part-time employees increased their health benefit use they also report increased affective commitment. On the other hand, full-time employees displayed a small, negative relationship between benefit use and affective commitment. This finding provides support for the idea that health benefits have differential effects on the attitudes of full and part-time employees.

Hypotheses 2a-b. The second major objective of this study was to determine the relationship between health benefit use and continuance commitment in full and part-time employees. Results indicate that benefit use is positively related to continuance commitment (hypothesis 2a). This is likely because leaving the organization would be a bigger sacrifice to those employees who frequently use their benefits who “have more to lose.” Although not hypothesized, main effects for benefit satisfaction and employee

work status were also found. Benefit satisfaction was found to be positively related to continuance commitment, which provides further evidence that health benefits are an important consideration that employees make when considering alternatives and weighing sunk costs. Results also indicated that full time employees ($M = 4.15$, $SD = .83$) reported significantly higher continuance commitment scores than part-time employees ($M = 3.91$, $SD = .87$). Although this effect is significant, I question whether such a small difference (.24) in reported continuance commitment scores is a practically meaningful result. It seems unlikely that a quarter point difference in scores between groups would have significant effects on group behavior. A Cohen's d of .17 indicates that this difference has a small effect size. Furthermore, meta-analytic results have suggested that there are not significant differences in the organizational commitment of full and part-time employees (Thorsteinson, 2003). Lastly, no support was found for the interaction between health benefit use and employee work status.

Hypotheses 3a-d. The last major objective of the present study was to determine the relationship between health benefit satisfaction and health benefit use on union loyalty in full and part-time employees. Previous researchers have suggested that negotiating health benefits for employees through collective bargaining may influence how members feel about the union (Sinclair et al., 1995). Results of this study indicated that benefit satisfaction is positively related to union loyalty, but benefit use is unrelated. A significant difference in union loyalty was found between full ($M = 3.45$, $SD = .89$) and part-time ($M = 3.29$, $SD = .91$) employees. Again, I have doubts as to whether this difference is practically meaningful. It seems unlikely that those scoring 3.29 or 3.45

would behave significantly different from one another. Cohen's d for this difference is .27, indicating small effect size. Similar to hypothesis 1, no support was found for an interaction between health benefit use and health benefit satisfaction (hypothesis 3c) or for a three-way interaction between health benefit use, satisfaction, and employee work status (hypothesis 3d).

There are several potential reasons why hypothesis 3c and 3d were not supported in this study. The first possibility is that other variables or confounds were overlooked in the model. For example, individual difference variables related to the union, such as union participation, were not examined. Furthermore, benefit use could be mediated by another variable, such as union instrumentality or value of individual benefits. Another explanation is that health benefits are too distal of predictors to predict union loyalty. Perhaps the most appropriate outcomes of health benefit use are also related to benefits.

Limitations

There are a number of limitations that should be considered when examining the results of this study. The first is that this study employed a cross-sectional design. Cross-sectional designs are non-experimental, and therefore offer no basis for inferring causality. Additionally, it is very possible that a variable or confound of interest was missed, which could potentially explain why some hypothesized relationships were not present. For example, cost of benefits/health care was not evaluated and could have had direct influences on both health benefit satisfaction and health benefit use.

Another potential limitation of the current study is that the benefit use measure may be missing indicators. For example, no information was gathered on how often

employees used their vision or dental benefits, which are both aspects of health benefits that were asked about in the health benefit satisfaction measure. Therefore, it is possible that meaningful variance is missing from the benefit use measure. It is also possible that continuance commitment was not measured appropriately. Some researchers have conceptualized continuance commitment as a two factor construct: perceived sacrifice and perceptions of available alternatives (Meyer et al., 2002). However, this study conceptualized continuance commitment as a single factor encompassing both perceived sacrifice and availability of alternatives. Lastly, there was a large difference in the number of part-time (n = 386) and full-time (n = 1452) employees that participated in the study, and unequal sample sizes can potentially reduce statistical power (Rosenthal & Rosnow, 2008).

Implications and Future Research

This study provides clear evidence that health benefits are an important area for organizations to remember when considering employee attitudes. Benefit satisfaction was found to predict affective organizational commitment, continuance organizational commitment, and union loyalty, which suggests that it may be a particularly important variable for both companies and unions to cultivate. This is fitting as there is a great deal of previous research that organizations can utilize to help increase employee benefit satisfaction.

Flexible benefits plans have been shown to increase employees' benefit satisfaction due to greater decision control in choosing desired benefits (Lee, Singhapakdi, & Too, 2008). Tremblay, Sire, and Pelchat (1998), proposed that in order

for benefit satisfaction to be increased, the organization must also take into account suggestions made by employees, emphasizing the role of communication. This has also been related to employee distributive and procedural justice perceptions. Distributive justice refers to the perceived fairness of outcomes or allocations and procedural justice refers to perceived fairness of process elements (Cropanzano, Byrne, Bobocel, & Rupp, 2001). Researchers have shown that procedural justice is a better predictor of benefit satisfaction than distributive justice (Arnold & Spell, 2006; Tremblay et al, 1998). Overall, employers should ensure that the processes through which benefits are allocated are fair, communication is open and accurate, and that employees are involved in making decisions regarding their benefits. Because the previous literature has focused on predictors of benefit satisfaction from the company's perspective, future research should also examine predictors of benefit satisfaction through the lens of the union. It is possible that different variables would be important for the union to focus on, given that the exchange relationship between the union and member is inherently different than the exchange relationship between the company and employee.

In addition to the findings related to benefit satisfaction, this study found partial support for the differential influence of health benefits on the employee attitudes of full and part-time employees. Employee work status moderated the relationship between benefit use and affective commitment such that as part-time employees used their benefits more often, affective commitment increased; whereas full-time employees increased their benefit use affective commitment slightly decreased. These results provide support for the provision of health benefits to part-time employees. However,

the interaction effects found in this study accounted for very little variance, so researchers and organizations should take this into account when making decisions. Furthermore, it is important to replicate these results in other retail environments to ensure that these findings are robust.

The current study was unique because of the specific focus on employee health benefits. Previous literature generally does not distinguish between different types of benefits when examining antecedents and outcomes of benefit satisfaction (Williams, 1995; Williams et al., 2002), but rather examines satisfaction in relation to all benefits received. One exception to this is Muse et al. (2008) who specifically examined the effects of work-life benefits (e.g. childcare assistance, flex-time, employee assistance programs, tuition reimbursement) on affective commitment. The authors determined that work-life benefit use and benefit value predicted affective commitment. In the current study, benefit use was not found to predict affective organizational commitment or union loyalty, suggesting that the increased use of health benefits does not contribute to employees' sense of support. This contrast between the finding of the present study and those of Muse et al. (2008) suggest that the use of specific benefits has differential effects on employee attitudes. Future research could examine how satisfaction with different aspects of employee benefits (health, retirement, work-life, etc.) relates to commitment or other outcomes of interest such as job satisfaction or turnover intentions.

Another interesting variable that could be examined in relationship to employee benefits is benefit value. As mentioned above, Muse et al. (2008) examined employee perceptions of benefit value, which is measured by asking participants how valuable they

feel each benefit is to them. Researchers have argued that benefits that are viewed as valuable will be more influential over employee attitudes than benefits that are not valued (Lambert, 2000). It is possible that benefit value is a better indicator of benefit importance than benefit use, and therefore may moderate the relationship between benefit satisfaction and employee attitudes.

Future research should also further investigate the relationship between health benefits and employee work status. It may be beneficial to examine which employees really identify as “part-time.” This could be done by asking employees about their work status or by examining the effect of hours worked per week. For example, many of the part-time employees that took part in the current study had working hours similar to full-time employees. The average number of hours worked for full-time employees was 42.01, while the average number of working hours for part-time employees was 32.99 per week. Furthermore, 42.1% of part-time employees reported working an average of 40 hours per week, indicating that it is possible that some part-time employees have more of a “full-time” mindset.

Recent research has demonstrated that part-time employees are not necessarily a homogenous group. Martin and Sinclair (2007) created a typology of the different types of part-time employees, reasoning that part-time workers differ in the nature of their non-work roles. Some PT workers attend school, have children, or hold another job elsewhere. Part-time workers also differ in the proportion of income they earn for their households. Using these differences, the authors divided PT employees into eight groups. Future research should examine the relationship between health benefits and employee

attitudes among the different classifications of part-time employees. It is likely that part-time employees who hold no other jobs and earn most of their household income from that job would respond and behave very similarly to full-time employees. However, differences may come to light when examining part-time employees who hold another job, are attending school, or do not earn the majority of household income through the part-time job.

Some may dispute that the passage of the Patient Protection and Affordable Care Act (PPACA), which goes into effect in 2014, may negate the importance of health benefit research, as all organizations employing more than 50 workers will be required to offer benefits. I would counter this argument by noting that if more employees are going to be receiving employer sponsored health benefits, it is even more important to understand how benefits affect employee attitudes as a larger proportion of the workforce will be affected. Furthermore, the benefit constructs examined in the present study, benefit use and benefit satisfaction, are still going to fluctuate given the variation in coverage levels and benefit systems between organizations. Additionally, if the PPACA does have an impact on how health benefits affect employee attitudes it is important to understand the mechanisms through which health benefits currently influence employees. If we do not have a thorough understanding initially it will be difficult to document change.

Conclusion

This study contributed to current knowledge on the relationship between health benefit use and satisfaction on commitment in companies and unions. Overall, strong

support was found for benefit satisfaction as a predictor of affective organizational commitment, continuance organizational commitment, and union loyalty. As expected, benefit use was related to continuance organizational commitment, but was unrelated to affective organizational commitment or union loyalty. This suggests that increased benefit use does not contribute to employees' sense of support from the company or the union. Future research should examine a wider variety of benefits-related variables and outcomes, as well as differential relationships between different classifications of part-time employees.

FIGURES AND TABLES

Figure 1. Proposed relationships in Hypothesis 1d

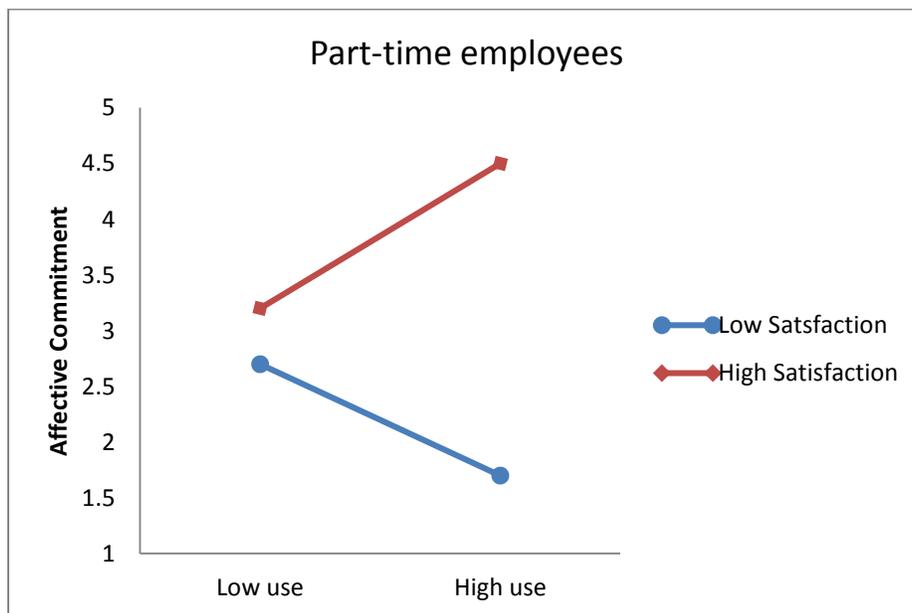
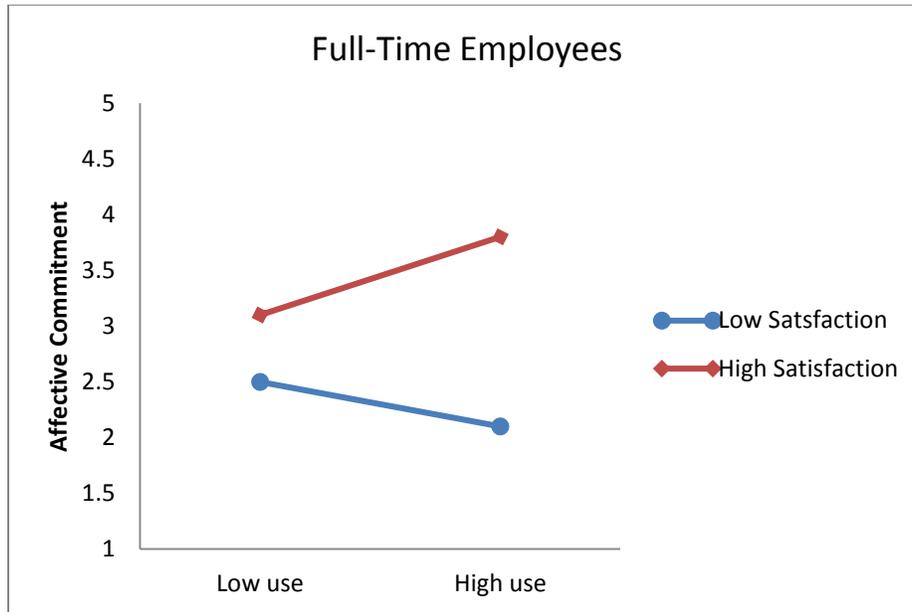
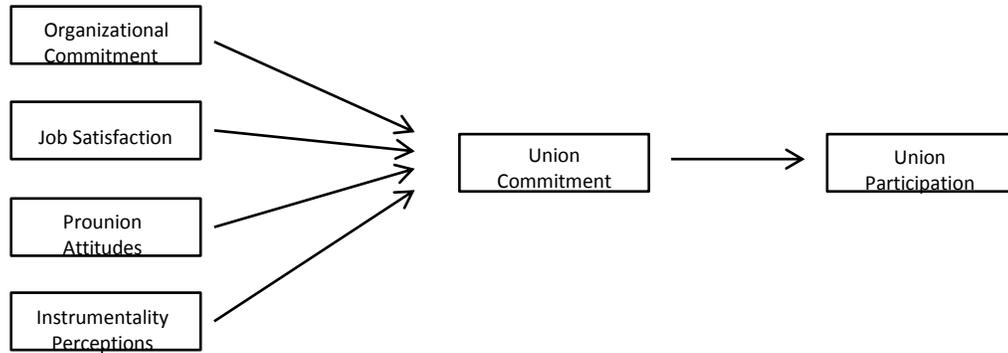


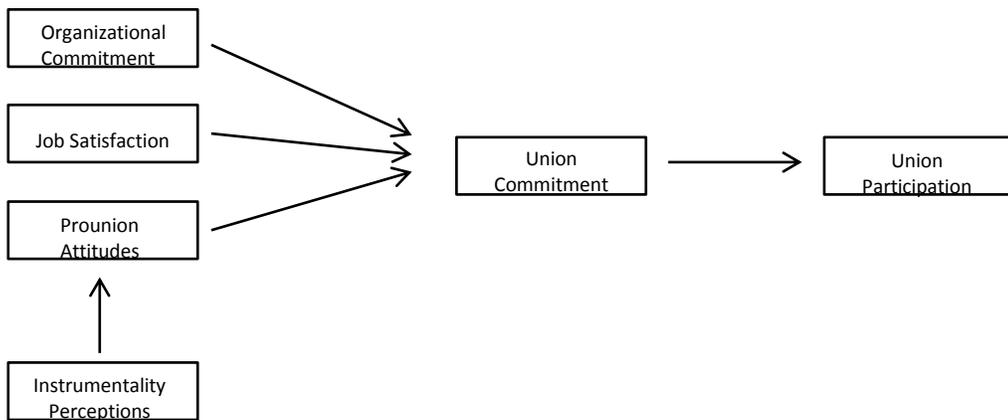
Figure 1. Proposed relationships in hypothesis 1d: employee work status will moderate the proposed interaction between health benefit satisfaction and health benefit use, such that the proposed interaction is more pronounced in part-time employees.

Figure 2a-d. Models of Union Commitment Antecedents and Consequences

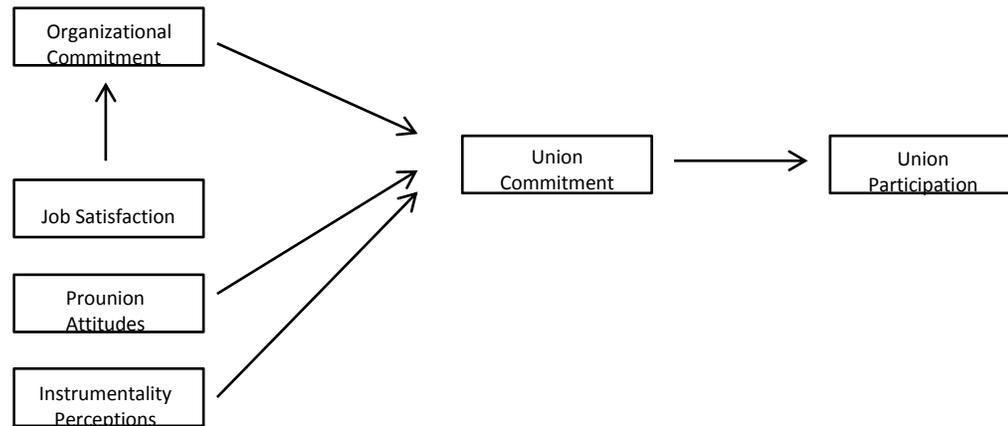
2a. Barling, Fullager, and Kelloway



2b. Newton and Shore



2c. Iverson and Kuruvilla



2d. Integrative Model

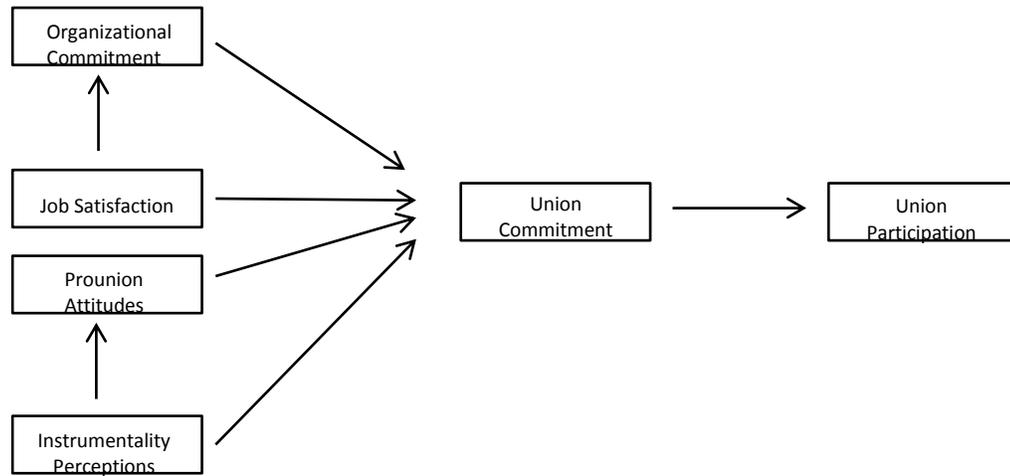


Figure 2a-d. Adapted from Barling, et al. (1992), this figure demonstrates different proposed models of union commitment antecedents.

Figure 3. Benefit satisfaction measure scree plot

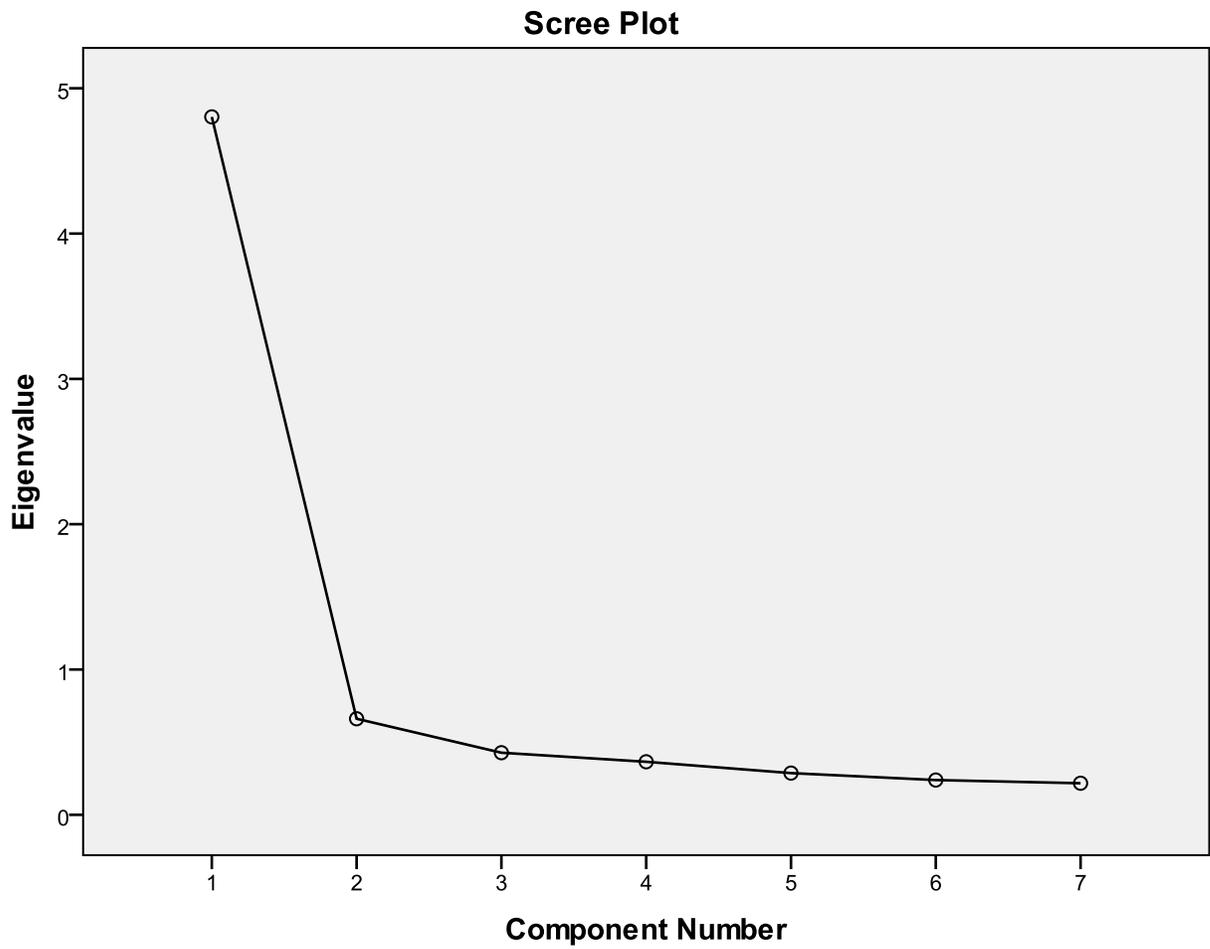


Figure 3. Scree plot for benefit satisfaction demonstrating a drastic drop in eigenvalues following the first component.

Figure 4. Interaction between Health Benefit Use and Employee Work Status

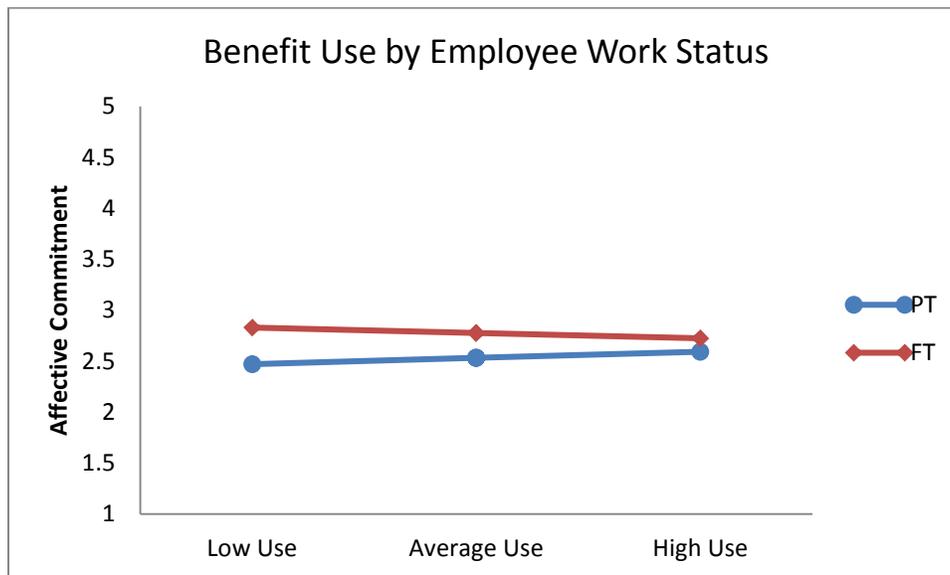


Figure 4. Results indicated that there is no relationship between benefit use and affective commitment in part-time employees, but there is a slightly negative relationship between benefit use and affective commitment in full-time employees.

Table 1. *CFA Results for Study Measures.*

	S-B χ^2	df	CFI	SRMR	RMSEA
Commitment Variables	202.99	32	.98	.03	.05

Notes. S-B χ^2 = Satorra-Bentler chi square; df = degrees of freedom; CFI = comparative fit index; SRMR = standardized root mean residual; RMSEA = root-mean-square error of approximation. Commitment variables include affective commitment, continuance commitment, and union loyalty.

Table 2. *Descriptive Statistics and Bivariate Correlations for Study Variables.*

Variable	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7	8	9
1. Age	49.11	11.86	1								
2. Gender	1.62	.49	.08**	1							
3. Number of kids at home	.72	1.05	-.04	.10**	1						
4. Employee Work Status	1.78	.41	.18**	-.12**	-.00	1					
5. Benefit Use	7.35	4.09	.11**	.11**	.20**	.08**	1				
6. Benefit Satisfaction	3.60	.81	-.03	-.02	-.02	-.04	.02	1			
7. Union Loyalty	3.42	.89	.16**	-.01	-.00	.08**	.04	.21**	1		
8. Affective Commitment	3.40	.92	.13**	.09**	.07**	.02	.01	.28**	.38**	1	
9. Continuance Commitment	4.09	.84	.11**	.05*	.03	.12**	.12**	.10**	.21**	.22**	1

Notes: * $p < .05$ (2-tailed); ** $p < .01$ (2-tailed).

Table 3. *Hypothesis One Results: Affective Commitment*

<i>Variables entered</i>	<i>B</i>	<i>SE B</i>	<i>t</i>	Cumulative <i>R</i> ²	ΔR^2
Step 1				.022	.022*
Age	.01	.00	4.31*		
Gender	.14	.04	3.10*		
Number of Children	.06	.02	2.97*		
Step 2				.101	.079*
Status (FT or PT)	.05	.05	.86		
Benefit Satisfaction	.31	.03	12.40**		
Benefit Use	-.01	.01	-1.41		
Step 3				.103	.003
Use X Satisfaction	.00	.01	.12		
Status X Use	-.03	.01	-2.12*		
Status X Satisfaction	-.06	.06	-.94		
Step 4				.104	.000
Status X Satisfaction X Use	.01	.02	.66		

Notes: * $p < .05$, ** $p < .01$, *B* is the unstandardized coefficient. *SE B* is the standard error of *B*.

Table 4. *Hypothesis Two Results: Continuance Commitment*

<i>Variables entered</i>	<i>B</i>	<i>SE B</i>	<i>t</i>	Cumulative <i>R</i> ²	ΔR^2
Step 1				.016	.016*
Age	.01	.00	4.40**		
Gender	.11	.04	2.55*		
Number of Children	.02	.02	.81		
Step 2				.042	.027*
Status (FT or PT)	.20	.05	4.10**		
Benefit Satisfaction	.10	.02	4.25**		
Benefit Use	.02	.01	3.50**		
Step 3				.043	.00
Status X Use	-.01	.01	-.49		

Notes: * $p < .05$, ** $p < .01$, *B* is the unstandardized coefficient. *SE B* is the standard error of *B*.

Table 5. Hypothesis Three Results: Union Loyalty

<i>Variables entered</i>	<i>B</i>	<i>SE B</i>	<i>t</i>	Cumulative <i>R</i> ²	ΔR^2
Step 1				.024	.024*
Age	.01	.00	6.49**		
Gender	-.01	.04	-.13		
Number of Children	-.00	.02	-.18		
Step 2				.071	.048*
Status (FT or PT)	.12	.05	2.29*		
Benefit Satisfaction	.23	.03	9.26**		
Benefit Use	.00	.01	.69		
Step 3				.073	.002
Use X Satisfaction	-.01	.01	-.823		
Status X Use	-.00	.01	-.22		
Status X Satisfaction	-.11	.06	-1.69		
Step 4				.074	.001
Status X Satisfaction X Use	.02	.02	1.22		

Notes: * $p < .05$, ** $p < .01$, *B* is the unstandardized coefficient. *SE B* is the standard error of *B*.

APPENDICES

Appendix A

Measures

Health Benefit Use

1. In the last 12 months, how many times did you or your dependents go to the emergency room to get care?
2. In the last 12 months, how many times did you or your dependents go to a doctor's office or clinic (not counting the emergency) room to get care?

Health benefit satisfaction

How satisfied are you with...

1. The quality of your medical insurance?
2. Your vision benefits?
3. Your dental benefits?
4. Your prescription benefits?
5. Your prepaid wellness benefits?
6. The available in-network medical providers?
7. The quality of the medical care you receive?

1 (very dissatisfied) – 5 (very satisfied) 6 (N/A)

Affective organizational commitment

1. I am proud to tell others that I am part of the [Company Name] organization.
2. I talk up [Company Name] to my friends as a great employer to work for.
3. I find that my values and [Company Name]'s values are very similar.

Continuance organizational commitment

1. I dread the thought of what might happen if I quit my job without having another lined up.
2. It would be very difficult for me to find another job that is as good as the one I have now with [Company Name].
3. I have too much at stake to change jobs right now.
4. It would be very hard for me to quit my [Company Name] [Company Name] job even if I wanted to.

Union Loyalty

1. My values and the Union's values are very similar.
2. I talk up Local 876 to my friends as a great organization to be a part of.
3. I feel a sense of pride being a part of the Union.

Appendix B

Critical values for Hartley's F_{\max} Test

(n - 1) per group	Number of Variances Compared										
	2	3	4	5	6	7	8	9	10	11	12
2	39.00	87.50	142.00	202.00	266.00	333.00	403.00	475.00	550.00	626.00	704.00
3	15.40	27.80	39.20	50.70	62.00	72.90	83.50	93.90	104.00	114.00	124.00
4	9.60	15.50	20.60	25.20	29.50	33.60	37.50	41.40	44.60	48.00	51.40
5	7.15	10.80	13.70	16.30	18.70	20.80	22.90	24.70	26.50	28.20	29.90
6	5.82	8.38	10.40	12.10	13.70	15.00	16.30	17.50	18.60	19.70	20.70
7	4.99	6.94	8.44	9.70	10.80	11.80	12.70	13.50	14.30	15.10	15.80
8	4.43	6.00	7.18	8.12	9.03	9.80	10.50	11.10	11.70	12.20	12.70
9	4.03	5.34	6.31	7.11	7.80	8.41	8.95	9.45	9.91	10.30	10.70
10	3.72	4.85	5.67	6.34	6.92	7.42	7.87	8.28	8.66	9.01	9.34
12	3.28	4.16	4.79	5.30	5.72	6.09	6.42	6.72	7.00	7.25	7.48
15	2.86	3.54	4.01	4.37	4.68	4.95	5.19	5.40	5.59	5.77	5.93
20	2.46	2.95	3.29	3.54	3.76	3.94	4.10	4.24	4.37	4.49	4.59
30	2.07	2.40	2.61	2.78	2.91	3.02	3.12	3.21	3.29	3.36	3.39
60	1.67	1.85	1.96	2.04	2.11	2.17	2.22	2.26	2.30	2.33	2.36
∞	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00

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