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This paper studies how information on costs and prevalence of long-term (LTC) care shapes individuals' willingness to pay (WTP) for long-term care insurance (LTCI) using a randomized experiment on a representative Italian sample. The design allows for causal identification of the effects of cost-risk and fiscal information on stated WTP. Results show that factual information about costs and risks of LTC significantly increases the monthly WTP by about €3—around 15% relative to the control mean—while the fiscal message has no significant impact. The effect is robust across specifications and driven by groups initially less informed, such as women and the uninsured. By contrast, extensive-margin results are not stable, suggesting that information mainly affects how much individuals are willing to contribute, not whether they would buy insurance. Aggregating individual WTP to the national level implies a potential annual fund of €13–13.7 billion, roughly 8–12% higher than the baseline and equivalent to about 15% of households' expenses and one-third of current public longterm care spending.

Willingness to Pay for Long-Term Care: Experimental Evidence from Italy[1]

Filippo Maurici and Carlo Savino*

Abstract

This paper studies how information on costs and prevalence of long-term (LTC) care shapes individuals' willingness to pay (WTP) for long-term care insurance (LTCI) using a randomized experiment on a representative Italian sample. The design allows for causal identification of the effects of cost-risk and fiscal information on stated WTP. Results show that factual information about costs and risks of LTC significantly increases the monthly WTP by about €3—around 15% relative to the control mean—while the fiscal message has no significant impact. The effect is robust across specifications and driven by groups initially less informed, such as women and the uninsured. By contrast, extensive-margin results are not stable, suggesting that information mainly affects how much individuals are willing to contribute, not whether they would buy insurance. Aggregating individual WTP to the national level implies a potential annual fund of €13–13.7 billion, roughly 8–12% higher than the baseline and equivalent to about 15% of households' expenses and one-third of current public long-term care spending.

Keywords: long-term care insurance; willingness to pay; randomized experiment.

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1. Introduction

As populations age across advanced economies, the financial and social sustainability of long-term care systems has become a central policy concern. In Europe, the median age of the population is projected to increase by 5.8 years by 2100, significantly affecting the demographic groups most likely to require assistance with daily activities.[2] With longevity gains outpacing improvements in health at older ages, the demand for long-term care—both formal and informal—is set to rise sharply. At the same time, changing family structures, declining fertility rates, and rising female labor force participation— traditionally the main source of unpaid care—are reducing the availability of informal caregiving. These twin demographic and societal shifts put mounting pressure on public long-term care systems and call for new solutions to finance and organize care provision.

One such solution is the development of a private long-term care insurance (LTCI) market. In theory, private LTCI could help individuals smooth consumption over the life cycle and hedge against the uncertain and potentially catastrophic costs of dependency. It could also relieve public budgets and enable more equitable access to care. Yet despite its potential, the private LTCI market remains strikingly small. In most European countries, market penetration is below 5%, and even in the United States—where the case for private insurance is arguably stronger—only a small fraction of older adults holds a policy. This misalignment between theoretical appeal and real-world uptake has spurred a body of research across economics, public policy, and behavioral science. In the U.S. context, the limited demand for LTCI is often explained by a combination of factors: adverse selection, high administrative costs, limited product transparency, and the crowding-out effects of means-tested programs such as Medicaid (Brown and Finkelstein, 2008; Gruber, 2022). Moreover, studies such as Davidoff (2010) suggest that many older adults behave as if they are "self-insuring" through housing wealth, particularly when they have no strong bequest motives.

In Europe, however, the institutional and cultural context differ significantly. Public long-term care programs—though varied in generosity and design—typically provide broader baseline coverage, reducing the marginal value of private insurance. More importantly, long-term care decisions are embedded in cultural norms of familial obligation. Informal caregiving remains prevalent, especially in Southern and Central Europe, where it is often seen not just as a fallback, but as a moral duty. These cultural norms influence expectations about who should provide care and how it should be financed, thereby shaping individual attitudes toward private insurance. Empirical studies have shown that familistic cultures are associated with lower expectations of state support and lower demand for formal long-term care solutions (Costa-Font, 2010; Canta and Pestieau, 2013).

[2] See Eurostat, Population projections in the EU.

Despite these institutional and cultural factors, the need for sustainable care financing in Europe is growing. Public systems face fiscal stress, and the current reliance on informal care may be unsustainable as demographic and labor market dynamics shift. Policymakers are thus increasingly interested in whether private LTCI could become a meaningful complement to public provision—and if so, under what conditions. This raises crucial questions: Do individuals accurately perceive the risks and costs associated with long-term care? Are they aware of the financial tools available to manage these risks? Can targeted information or fiscal incentives nudge them toward considering insurance as a viable option? In this paper, we address these questions by studying the willingness to pay (WTP) for LTCI in Italy, using data from the Italian Survey of Consumer Expectations (ISCE). We implement a two-stage experimental design embedded in a nationally representative online survey. In the first stage, a randomly selected group receives factual information about the prevalence, costs, and risks of dependency in old age. In the second stage, a subset of this group receives additional information about the tax deductibility of LTCI. This design allows us to isolate the effects of information on individuals' perceived relevance of LTC, their familiarity with insurance instruments, and their stated willingness to pay for coverage.

Italy provides a particularly compelling case study. The country is aging rapidly, public coverage for non-self-sufficiency is relatively limited, and informal care remains the dominant mode of support. Yet at the same time, private LTCI coverage is virtually non-existent. By examining how information influences attitudes and WTP in this setting, we contribute to a growing literature on the behavioral and informational barriers to insurance demand. More broadly, our findings speak to the design of sustainable care financing strategies in aging societies where traditional family support structures may no longer suffice.

1.1 Related Literature

The theoretical foundations of insurance demand rest on the premise that individuals seek to mitigate financial risks arising from uncertain life events. Yaari (1965) was among the first to show that under lifetime uncertainty, full annuitization is optimal for a utility-maximizing individual without a bequest motive. Extending this framework, Lewis (1989) incorporates dependent utility, modeling life insurance as a tool to protect beneficiaries. Subsequent works by Hakansson (1969) and Fortune (1973) explore the joint optimization of consumption, saving, and insurance decisions in a stochastic lifecycle setting.

Empirical research confirms the central role of income, financial development, and demographic variables in shaping life insurance demand. Using extensive cross-country data, Beck and Webb (2003) and Feyen et al. (2013) find that life insurance consumption is positively associated with income per capita, financial sector development, and pension system structure, but negatively affected by inflation and state ownership. Outreville (1996)

emphasizes that in developing countries, regulatory environment and market competition play a decisive role. Furthermore, Outreville (2015) argues that demand for insurance is also shaped by individual characteristics like education and human development, which influence relative risk aversion. Inkmann and Michaelides (2012) examines bequest motives in explaining insurance choices, while Bhatia et al. (2021) offers a comprehensive review of behavioral and psychological factors influencing insurance purchase decisions.

The macroeconomic impact of insurance markets has been widely documented. Arena (2008) and Chang et al. (2014) confirm that both life and non-life insurance sectors contribute positively to GDP growth, financial stability, and capital formation— though the strength and direction of these effects vary by institutional context. Insurance development also plays a role in household financial protection and broader welfare outcomes, as reflected in models of mortality delta and health risk sharing (Koijen et al., 2016). Despite their diversity, these studies converge on the conclusion that insurance markets are vital to both individual security and macroeconomic performance.

The private LTCI market remains remarkably small, despite the substantial financial risks posed by long-term care needs in old age. Numerous studies have explored the reasons behind this limited take-up, highlighting a combination of market imperfections, behavioral frictions, cultural norms, and public policy interactions. A central explanation involves information frictions and misperceptions. For instance, Boyer et al. (2020) uses a stated-choice experiment to show that informational barriers significantly suppress LTCI demand, more so than selection effects, implying that welfare losses in this market stem primarily from these frictions. On the behavioral side, Gottlieb and Mitchell (2020) introduces a model of narrow framing, showing that individuals who evaluate insurance decisions in isolation rather than contextually are substantially less likely to purchase LTCI—an effect stronger than both risk aversion and adverse selection. Meanwhile, aside from the LTCI market, D'Amato et al. (2023) examines how date labeling on perishable foods affects consumer behavior, using causal evidence from in-store experiments. Specifically, the study finds that while expiry dates influence consumers' valuation of food items, the specific type of date label has minimal impact. However, educating consumers about the meaning of these labels reduces their willingness to pay for potentially unsafe food, though it does not increase the valuation of items perceived as more durable. This asymmetry—akin to a form of insurance—suggests that both consumer attention and baseline understanding play crucial roles in interpreting date labels, with implications for the design of effective consumer education campaigns.

Demand-side constraints have also been extensively examined through structural modeling. Braun et al. (2019) incorporates Medicaid, administrative costs, and asymmetric information into a quantitative equilibrium model, showing that even with significant risk exposure, only about 10% of Americans over 62 purchase LTCI. Specifically, Braun et al. (2019) reflects both the disincentive effects of public coverage for low-income individuals and the role of high costs and adverse selection for wealthier households. Similarly, Brown and

Finkelstein (2007, 2009, 2011) highlight consumer misperceptions, behavioral biases, and limited WTP as major barriers to uptake. While supply-side inefficiencies—such as high loadings and inadequate benefits—exist, these alone cannot explain the market's small size. Additional demand distortions arise from the treatment of housing wealth. Davidoff (2010) argues that for many elderly individuals, home equity functions as a form of passive self-insurance. In the absence of strong bequest motives, individuals draw down housing assets when care needs arise, diminishing the perceived value of formal insurance. Simulations confirm that this "asset commitment" effect can substantially reduce demand relative to models that exclude housing wealth. That is, there is no need to insure against possible adverse effects in the future, as no-bequest agents intend to liquidate their housing assets if needed, even if it means paying more overall. Ameriks et al. (2020) highlights that utility from care itself, not just longevity or bequests, shapes late-life saving behavior and insurance demand. Fleurbaey et al. (2016) examines retirement under lifetime uncertainty and suggests that market incompleteness leads households to self-insure through precautionary savings. While, in a related framework, Fleurbaey et al. (2022) analyzes fairness in the distribution of accidental bequests, offering normative arguments for policy interventions. In this sense, public policy, particularly Medicaid, plays a critical role in shaping market outcomes. Brown and Finkelstein (2008) estimates that Medicaid imposes a substantial implicit tax on private LTCI—between 60% and 75% for median-wealth individuals—thereby reducing its attractiveness. Zweifel and Struwe (1998) also finds that public program design can crowd out private insurance demand, suggesting a need for coordinated reforms rather than merely expanding the private market. The crowding-out hypothesis is empirically supported by Sloan and Norton (1997), observing that Medicaid reduces LTCI demand among the elderly, alongside evidence of adverse selection but little support for bequest or exchange motives.

The empirical role of informal caregiving is further confirmed by Ko (2022), which shows that private knowledge about children's caregiving intentions introduces adverse selection into the insurance market. Mommaerts (2025) finds that the availability of informal care reduces LTCI take-up by seven percentage points and lowers Medicaid expenditures, while also suggesting that cash compensation for informal care could increase insurance demand and family welfare. Tennyson and Yang (2014) and Zhou-Richter et al. (2010) provide supporting evidence that caregiving experience and awareness shape insurance behavior. Coe et al. (2015) further confirms that individuals whose parents needed nursing home care are more likely to expect similar needs themselves, indicating a learning effect from personal experience. Eling and Ghavibazoo (2019) identifies both demand- and supply-side frictions, including adverse selection, limited financial literacy, and reliance on informal care.

Fiscal implications of informal care provision have also come under scrutiny. Geyer et al. (2017) argues that while informal care is often seen as a cost-saving alternative to

subsidized formal care, it imposes indirect fiscal costs due to caregivers' reduced labor force participation. Using a structural model of labor supply and care arrangements, they quantify the resulting loss in tax revenue, social contributions, and the increase in transfer payments, also examining fiscal losses from non-take-up of formal care services. Several studies have proposed policy or product design innovations to address market inefficiencies. Akaichi et al. (2020) uses discrete choice experiments (DCEs) involving over 15,000 individuals to estimate WTP for different insurance attributes. The study finds that insurance uptake decreases by 1 percentage point with every $100 premium increase, while lifetime benefits, voluntary policy options, and the removal of health checks significantly raise WTP. Brown and Warshawsky (2013) explores life care annuities—integrated products that combine annuities and LTCI—as a way to improve risk pooling and reduce adverse selection, showing that gender-based pricing can expand access for traditionally underserved populations.

From a public finance perspective, Goda (2011) evaluates the impact of state tax subsidies for LTCI in the U.S. and finds that while these subsidies increase insurance coverage by 2.7 percentage points, that is, a 28% rise, the effect is concentrated among high-income, asset-rich individuals. Simulations suggest that each dollar spent on tax subsidies generates approximately $0.84 in Medicaid savings, with over half accruing to the federal government. International experience also offers valuable policy lessons. Rhee et al. (2015) compares LTCI systems in Germany, Japan, and South Korea, recommending phased introduction of LTCI in middle-income countries with initially limited coverage. In the Korean context, Kim and Lim (2015) finds that government subsidies significantly increase both home and institutional care use, with formal care substituting informal care at the intensive margin but not the extensive one—highlighting the importance of targeting based on health status.

While much of the literature on the LTCI market and its financing is based on U.S. data (Gruber, 2022), the European context presents distinct institutional features—particularly concerning the interplay between formal and informal care (Sliwinski et al., 2013; Tien and Yang, 2014)—which are often challenging to measure accurately. In Europe, long-term care decisions are also shaped by cultural norms and family expectations regarding the care of elderly parents, in contrast to the U.S. setting analyzed by Davidoff (2010), where the underdevelopment of the LTCI market is largely attributed to the absence of a bequest motive. Carrino et al. (2018), focusing on Central European countries,[3] studies how elderly individuals adjust their informal care use in response to changes in the provision of formal care, finding that greater access to formal care leads to more informal care use, rather than less. This surprising complementarity suggests substantial unmet care needs and challenges standard economic models that treat formal and informal care as substitutes. In a broader European context, Balia and Brau (2014) analyzes formal and informal home

[3] Specifically, Austria, Belgium, France, and Germany.

care utilization using data from the first wave of SHARE (Borsch-Supan et al., 2013),[4] and shows that the relationship between formal and informal care varies by type—ranging from substitutability to complementarity—and that age, disability, and proximity to death are key determinants of care use. The findings of Balia and Brau (2014) call into question the effectiveness of policies that promote informal care solely as a cost-containment strategy. Focusing specifically on Spain, Jimenez-Martin et al. (2016) explores the limited development of the private LTCI market and its relationship with health insurance. Using SHARE data, Jimenez-Martin et al. (2016) finds that LTCI purchase is often conditional on also holding private health insurance, pointing to supply-side restrictions in the market. Despite this constraint, LTCI demand has grown, likely as a response to public budget cuts affecting Spain's long-term care system. Family dynamics also significantly influence insurance behavior. Informal care by close relatives is a dominant feature in long-term care provision, especially in systems where strong family ties are culturally embedded. Costa-Font (2010) shows that in Europe, familistic norms reduce expected coverage of LTCI by fostering reliance on informal caregiving.[5] This cultural crowding-out is robust across definitions and migrant subgroups. Similarly, Canta and Pestieau (2013) models LTCI provision as driven by intergenerational norms, where children care for parents in accordance with values transmitted during childhood, affecting the interaction between familial, market, and government care. Amilon et al. (2020) conducts a stated-preference discrete choice experiment on WTP for LTC in Denmark, finding that respondents value improvements in publicly financed services and that willingness to pay rises with age. Survey and experimental economics provide additional tools for understanding the behavioral components of LTCI demand. McClelland et al. (1993) uses real-stakes insurance experiments to show that individuals systematically over- or underreact to low-probability risks, exhibiting bimodal bidding behavior consistent with observed underinsurance in the data. In related works on belief formation, several survey-based studies outside the LTCI domain shed light on how information affects WTP. Guiso and Jappelli (2024b), using a large-scale information treatment in Italy, shows that informing individuals about hydrogeological risks increases both their willingness to contribute and the amount they are willing to pay for public prevention programs. Their findings mirror patterns in LTCI where underestimation of risk dampens demand, and beliefs about others' behavior influence individual choices. Other studies, such as Armantier et al. (2016), Cavallo et al. (2017), and Coibion et al. (2018, 2022), apply randomized survey designs to examine how consumers and firms update expectations. These studies consistently find that individuals revise beliefs in

[4] SHARE (Survey of Health, Ageing and Retirement in Europe) is a research infrastructure designed to study the impacts of health, social, economic, and environmental policies throughout the life course of European citizens and beyond.

[5] Coe et al. (2025), using U.S. Health and Retirement Study (HRS) data, shows that greater female bargaining power within couples increases the likelihood of long-term care insurance coverage.

Bayesian ways, albeit with significant heterogeneity and persistent information frictions. Such insights are directly relevant to LTCI, where subjective expectations of future care needs and policy reliability play an outsized role in shaping insurance behavior. Stantcheva (2023) emphasizes the broader methodological role of surveys as tools for capturing preferences, perceptions, and reasoning processes that are otherwise unobservable, particularly in policy-sensitive domains like insurance. Similarly, D'Acunto and Weber (2024) argues that subjective expectations are central to understanding economic decisions and should be integrated with observed behavior, not treated as secondary or unreliable data.

1.2 Outline

The paper proceeds as follows. Section 2 describes the data and experimental design, also providing a brief theoretical model, detailing the randomization procedure, information treatments, and balance across groups. Section 3 presents the empirical framework and main results. We first estimate the causal effects of information on individuals' willingness to pay for long-term care insurance (both intensive and extensive margins), then assess robustness across alternative specifications and population subgroups. Section 3.5 quantifies the potential aggregate funding capacity implied by our micro estimates, comparing it with public long-term care expenditure. Section 4 concludes.

2. Data and Experimental Design

We conducted our experiment within the Italian Survey of Consumer Expectations (ISCE), a newly launched survey on consumption and expectations that began in October 2023. ISCE is designed as a quarterly rotating panel and aims to interview a representative sample of Italian individuals. The survey collects rich information on demographic characteristics, household resources—including income and wealth components—consumption behavior, and expectations about both individual variables, such as future income and spending, and aggregate macroeconomic indicators, including inflation, unemployment, nominal interest rates, and economic growth.

2.1 Survey

The survey builds on two international experiences with online, high-frequency surveys. The New York Fed Survey of Consumer Expectations (Armantier et al., 2017) collects monthly information on consumers' views and expectations regarding inflation, employment, income, and household finances. Equivalently, the European Central Bank Consumer Expectations Survey (Bankowska et al., 2021) gathers comparable data from about 20,000 households in 11 countries in the euro area. Both surveys include a set of core questions asked in every wave, along with special modules that vary across waves. The sampling scheme is similar to those applied in many comparable surveys. The Italian resident population is stratified based on four criteria: area of residence (North-East, North-West, Central, and

South and Islands), age group (18–34, 35–44, 45–54, 55–64, over 65), gender, education (college degree, high school diploma, less than high school), and occupation (employed, unemployed). All interviews were conducted using a Computer Assisted Web Interviewing (CAWI) method. The ISCE Statistical Bulletin provides detailed information about the survey (Guiso and Jappelli, 2024a).

2.2 Experimental Design

To investigate the impact of information on individuals' perceptions and decisions regarding long-term care, we implemented a two-stage experimental design.

In the first stage, participants, denoted by G, were randomly assigned to one of two groups, G_1 and G_2. Individuals in group G_1 received factual information about the prevalence, costs, and financial risks associated with providing long-term care. Specifically, they were shown the following statement.

> *Information 1 (Only to G_1)*
>
> *In Italy, more than four million elderly individuals are not self-sufficient. The risk increases with age: over 40% of people aged over 80 require continuous assistance to perform basic daily activities such as walking, bathing, dressing, eating, and using the toilet. Just over two million people who meet specific eligibility criteria receive a monthly state allowance (indennità di accompagno) of approximately €540. The average monthly cost of continuous care for a non-self-sufficient person ranges from €1,800 to €2,500. As the population ages, the risks and costs associated with non-self-sufficiency are expected to increase.*

Consequently, we ask both groups two questions related to long-term care. These questions are designed to assess both the personal relevance of non-self-sufficiency and the awareness of financial instruments that can help manage its associated risks. The first question captures whether respondents have direct or indirect experience with individuals who require continuous care, while the second measures their familiarity with LTCI. Both questions require simple "Yes" or "No" answers. Together, they provide insight into how salient and well-understood the issue of non-self-sufficiency is within the population.

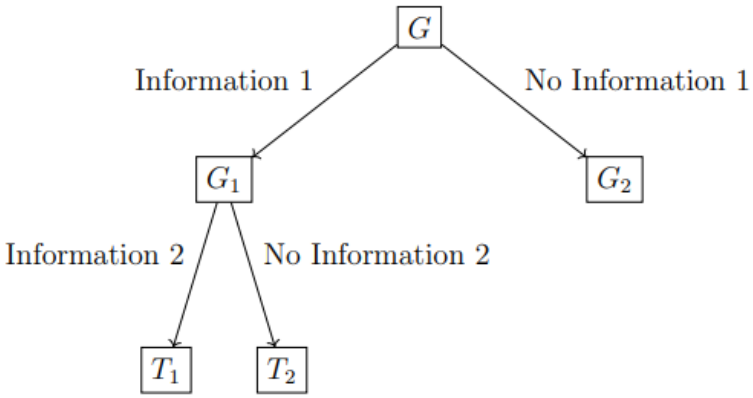


Figure 1: Experimental Design.

The second stage of the experiment provides another information layer only to a subgroup of G_1. Specifically, we divide the elements in G_1 to form two subgroups, labeled as T_1 and T_2. We endow the group T_1 with additional information.

> *Information 2 (Only to T_1)*
>
> *Premiums paid for insurance policies against the risk of non-self-sufficiency (Long-Term Care) are tax-deductible at 19% up to a limit of €1,290 per year. That is, if €1,000 is spent in a year on LTCI coverage, €190 can be deducted from taxes.*

Building on this new source of information, we elicit individuals' preferences for LTCIs. That is, we proceed to analyze individuals' willingness to purchase LTCIs. In particular, we assess both the likelihood of opting into coverage and the corresponding WTP for LTCI, conditional on interest in enrollment. Figure 1 provides a graphical representation of the stages of the experimental design, along with the informational treatments. In Appendix, we present the full set of survey questions designed to elicit respondents' willingness to pay for LTCI.

2.3 Theoretical Background and WTP Model

In this section we provide a simple theoretical background to the design of the Randomized Control Trial and the estimates. Consider a setting in which Individuals live two periods–0 and 1–with endowments w_0 and w_1, respectively. In the first one they are in good health and in the second one they will need with probability $\pi \in (0,1)$ long-term care that involves a fixed financial outlay L. In period 0, in exchange for the payment of a premium p, they are offered an insurance contract $\{C, p\}$ that pays a fixed amount C in the following period if they are no longer self-sufficient. Upon purchasing the coverage, the individual receives the proportional fiscal subsidy $\tau \in (0,1)$. We assume the period utility function to be of the logarithmic form (a special case of a CRRA utility function with parameter equal to one) to allow for convenient closed-form solutions. As customary, future utility is discounted by the factor $\beta \in (0,1)$. The intertemporal utility function of an insured individual is therefore described by

$$V_{insured}(p) = \ln(w_0 - (1-\tau)p) + \beta[\pi \ln(w_1 - L + C) + (1-\pi)\ln(w_1)]$$

We model an individual's willingness to pay for LTC insurance as the maximum insurance premium one is willing to pay p^* that equates the intertemporal expected utility of taking on the insurance contract in the intertemporal utility function to that of doing nothing. In the special case of $C = L$, p^* represents the price to pay to obtain the certainty equivalent of the lottery $\{\pi(w_1 - L) + (1 - \pi)w_1\}$, that is

$$V_{insured}(p^*) = \ln(w_0) + \beta[\pi \ln(w_1 - L) + (1 - \pi)\ln(w_1)]$$

Using the properties of the logarithms, we end up with the optimal condition, in closed form, for the maximum price an individual is willing to pay to purchase the cover C

$$\mathrm{p}^* = \mathrm{WTP} = \frac{w_0}{(1-\tau)}\left[1 - \left(\frac{w_1 - L}{w_1 - L + C}\right)^{\beta\pi}\right]$$

The underlying assumption of the experiment at the basis of this study is that awareness about the actual costs of LTC and fiscal treatment of premiums paid to cover its risk is incomplete and that if information on these is provided, then individuals rationally adjust their WTP accordingly. More specifically, the assumption is that the financial loss L is on average underestimated and that there is no (or incomplete) awareness of the fiscal subsidy guaranteed by the law. By inspecting the endogenous p^* we get comparative statics expressions

$$\frac{\partial WTP}{\partial L} > 0, \qquad \frac{\partial WTP}{\partial \pi} > 0, \qquad \frac{\partial WTP}{\partial \tau} > 0, \qquad \frac{\partial WTP}{\partial \beta} > 0$$

The interpretation of these results is quite straightforward. The marginal effects of L on WTP predicts that the greater is the future financial loss implied by the need of LTC, the more is an individual is willing to pay to insure against it. The same prediction is implied by π with regards to the probability of losing the ability to take care of themselves. Similarly, the effects of τ suggests that the more generous is the deduction rate, the more one would be willing to pay to obtain coverage. Finally, the last expression indicates that the more one discounts future utility, i.e., the higher is β, the less will the future loss L impact their overall expected utility and in turn the less will they be inclined to pay to purchase insurance.

The first randomization, G_1 and G_2, is designed to test a combination of the first two expression, L and π, whereas the second randomization, T_1 and T_2, is aimed at verifying expression the impact of τ. The last expression is tested through controlling for some crucial fixed effects, such as age and gender.

2.4 Descriptive Statistics

Table 1 summarizes the main characteristics of the 5,000 respondents drawn from ISCE. The sample is broadly representative of the Italian adult population, with an average age of about 49 years and a balanced gender composition—48% male and 52% female. A majority of respondents are married, and the typical household comprises around three members, reflecting the demographic structure of Italian families. Educational attainment is moderate:

just over half of individuals hold a high school diploma, while roughly one quarter have completed tertiary education. The geographical distribution is well balanced, with 20% of respondents residing in Central Italy and 34% in the South, the remainder being located in the North. Labor market participation also aligns with national averages, as nearly half of respondents are employed, about 9% are self-employed, and 18% are retired.

Average income levels correspond to roughly €2,000 in monthly disposable resources, indicating a sample that spans a wide range of economic conditions. Homeownership is widespread, as nearly eight in ten respondents own their dwelling, consistent with Italy's traditionally high rate of property ownership. Around one quarter report holding private health insurance, and nearly half have other forms of coverage—such as life or property insurance—suggesting a moderate engagement with private insurance markets.

Awareness and experience related to long-term care are considerably more limited. Only 36% of respondents report having heard of LTCI, and just 12% have direct or family exposure to situations of dependency. These figures highlight that, although the risk of non-self-sufficiency is relevant for a growing share of the population, knowledge of financial tools designed to mitigate it remains low. The average stated WTP for LTCI is approximately €25 per month, though responses are highly dispersed, indicating substantial heterogeneity in perceived need and financial willingness to contribute.[6] About 69% of individuals express at least some interest in purchasing coverage. Taken together, these statistics depict a population that is demographically balanced and economically diverse, but still only marginally aware of long-term care insurance—underscoring the informational barriers and behavioral frictions that may constrain the development of the private LTCI market in Italy.[7]

Building on Table 1, Table 2 compares the main variables across experimental groups to provide an initial picture of whether any noticeable differences emerge prior to the formal balance analysis. The control group G_2 includes respondents who did not receive any information; the first treatment group G_1 was exposed to information about the prevalence and costs of long-term care; and the second-stage treatment subgroup T_1, nested within G_1, also received information on the tax deductibility of LTCI premiums.

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[6] The LTC contribution under Article 86 of the CCNL ANIA—the national collective agreement for the insurance sector—corresponds to 0.50% of the employee's gross annual salary. Thus, for a gross annual salary of €50,000, this would amount to a monthly contribution of around €20. Although the estimates presented in this paper are derived independently and not computed in accordance with the CCNL ANIA, the resulting figures are remarkably close to those implied by the contractual parameters. This similarity reinforces the robustness of our analysis. The full text of the CCNL ANIA is available at:

https://www.ania.it/documents/35135/143842/CCNL+Dipendenti+22+febbraio+2017.pdf/1b121f91-8a8c-5aca-78db-090688112c53?t=1643623032716

[7] To obtain a conservative estimate of the effects, we code undecided respondents as having a null WTP. This mechanically lowers the average WTP, both in monetary terms (intensive margin) and in the likelihood of purchasing LTCI (extensive margin). In the main analyses, we exclude these respondents, while for the robustness analyses in Section 3.4, we apply the same coding.

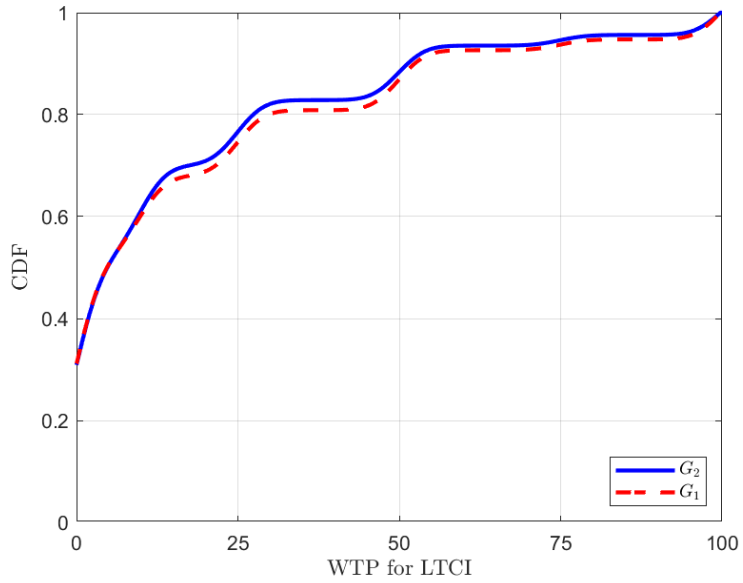


Figure 2: CDF of WTP for LTCI by Treatment group, G_2 (blue) and G_1 (red).

At first glance, the groups appear broadly comparable across all core characteristics. Average age is nearly identical, around 49 years, and the proportions of men, married individuals, and average family size differ only marginally. Educational attainment and regional residence are likewise very similar, as are employment patterns and income levels. Homeownership rates and the prevalence of private insurance coverage also display little variation, suggesting that random assignment likely achieved an even distribution of respondents across observable dimensions. More nuanced differences emerge in the variables most directly linked to long-term care. Awareness of LTCI is slightly higher among treated individuals—around 38% in G_1 and 37.5% in T_1 compared with 35% in the control group—while exposure to situations of dependency is relatively uniform. These small gaps may reflect random variation or the presence of mild pre-treatment differences in familiarity with insurance products.

Differences in WTP for LTCI are similarly modest but noteworthy. On average, treated respondents report slightly higher WTP—about €25.4 per month in G_1 and T_1 compared with €23.5 in G_2—while the proportion of individuals expressing a positive willingness to purchase coverage remains stable across groups, around 69%. Although these contrasts are not large enough to suggest systematic divergence, they provide an early indication that information about LTC risks and costs might already be associated with somewhat higher valuations of coverage. Overall, Table 2 suggests that before any statistical testing, the three groups are well aligned on demographic and economic traits, with only small, intuitive differences emerging for variables related to long-term care awareness and stated preferences. Figure 2 shows the smoothed cumulative distribution of the willingness to pay for LTCI across G_2 and G_1. The curve for the treated group lies consistently below that of the control, indicating first-order stochastic dominance. This pattern suggests that receiving information shifts the distribution of stated willingness to pay upward, with a higher share of individuals reporting

greater valuations for LTCI at any given threshold. Although the difference is not large in absolute value, it is systematic and points to an overall positive effect of information on respondents' perceived value of coverage.

2.4.1 Balance Tests

Table 3 reports the results of probit regressions assessing whether observable characteristics predict assignment to the different experimental groups. The estimated marginal effects confirm that the randomization worked as intended, as most coefficients are small in magnitude and statistically not significant. Across all specifications—assignment to G_1, to T_1, and to T_1 conditional on being in G_1—the models show limited explanatory power, indicating that no systematic differences emerge across groups once basic controls are accounted for.

A few isolated coefficients reach conventional significance levels but do not display a consistent pattern across models. Married individuals are slightly less likely to be assigned to the information groups, and those with higher education or employment status show marginally lower probabilities in some specifications, though these effects are modest and not robust. Awareness of LTCI is positively associated with assignment to G_1, but this appears to be a random fluctuation rather than an indication of bias, as no similar relationship is observed for the other treatments. Overall, the results confirm that observable demographics, socioeconomic conditions, and prior LTC-related experience do not systematically predict treatment assignment. The limited predictive power of the models reinforces the validity of the randomization procedure and supports the interpretation of subsequent treatment effects as causal. Figure 3 shows the means of key individual characteristics—namely the share of males, average (log) income, the proportion of respondents with health insurance, and the percentage aware of long-term care insurance—across the experimental groups. Figure 3 complements the balance tests in Table 3 by providing a visual check on the comparability of the samples. The means overlap almost perfectly across groups, with only negligible variations in any of the reported dimensions. In particular, gender composition, income levels, and insurance coverage appear nearly identical, while LTCI awareness differs only marginally and without a systematic pattern. These visual results confirm that the randomization produced balanced groups along the main observable characteristics, strengthening confidence in the internal validity of the experimental design.

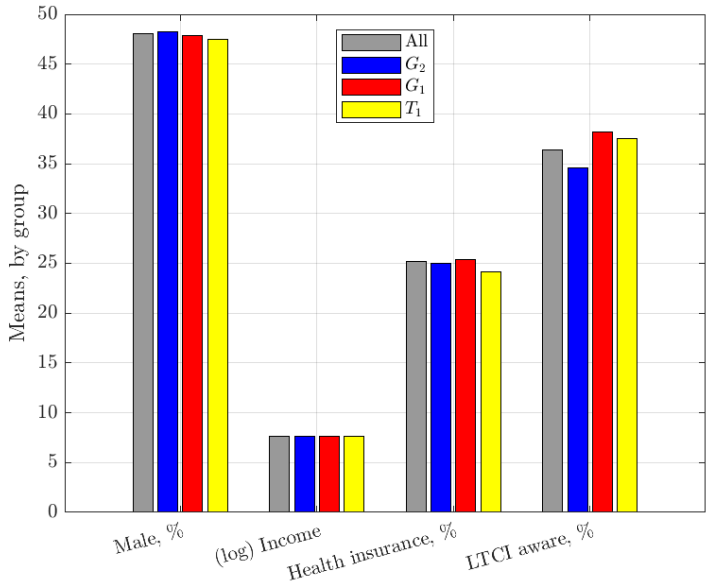


Figure 3: Group means for selected demographic and awareness variables, by Treatment group, All (grey), G_2(blue), G_1 (red), and T_1 (yellow).

2.4.2 Clusters

To better understand how individual characteristics shape awareness and stated demand for long-term care insurance, we explore heterogeneity across four key dimensions: gender (Table 4), age (Table 5), education (Table 6), and prior health-insurance status (Table 7). These dimensions capture the main drivers of heterogeneity typically associated with insurance behavior: gender and age relate to caregiving roles and life-cycle exposure to dependency risk; education proxies for information-processing capacity and financial literacy; and health-insurance status identifies individuals already engaged in private risk mitigation.

As shown in Table 4, men have higher income and greater access to private insurance products, with an average log income of 7.70 compared with 7.58 among women, and health-insurance coverage of 29% versus 21%. Men also show a higher mean WTP for LTCI—about €27 compared with €21 for women—and a greater probability of any positive WTP (72% versus 66%). Women, however, are more aware of LTCI (38% versus 34%). While men's WTP remains essentially stable across treatments, women's responses increase substantially once information is provided: their average WTP rises from €19.95 in the control group to €23.3 in both the information and fiscal treatments. This pattern suggests that informational exposure has a stronger behavioral impact among women, narrowing the initial gender gap in stated demand for LTCI.

Table 5 displays a clear age gradient. Younger respondents (≤34 years) report an average WTP of about €24 and awareness of 30%, while these values are stable to €24 and 38% among the middle-aged and increase to €27 and 40% among older individuals (65+). The proportion of respondents expressing a positive WTP declines slightly with age—from

72% among the youngest to 67% among the oldest—while health-insurance coverage drops from 31% to 16%. Both younger and older cohorts show relatively strong reactions to the information treatment, with increases in WTP particularly pronounced at the tails of the age distribution, consistent with higher uncertainty and risk salience in those groups.

Differences by education, summarized in Table 6, are also marked. Average WTP rises from €20.5 among respondents with only primary schooling to €26 among those with tertiary education, while the probability of any positive WTP increases from 66% to 73%. Health-insurance coverage follows the same pattern—18%, 24%, and 35%, respectively—confirming the close link between education, income, and financial engagement. Awareness of LTCI is roughly constant across education levels (35–37%), but informational treatments tend to increase awareness more effectively among the higher educated, suggesting that comprehension and assimilation of factual material depend partly on cognitive ability.

Finally, Table 7 highlights substantial contrasts by prior health-insurance status. Those with supplementary health coverage report higher income (average log income 7.90 versus 7.55), greater ownership of other insurance products (73% versus 40%), and higher exposure to long-term care situations (24% versus 8%). They are also more aware of LTCI (41% versus 35%) and express both higher average WTP (€31 versus €22) and a larger share with positive WTP (80% versus 65%). Within both groups, exposure to information modestly raises awareness and WTP, but the effect is strongest among the insured, who display an increase in average WTP from about €30 in the control group to over €33 after the informational and fiscal treatments. Across all clusters, income, education, and prior insurance experience are closely related to both awareness and the intensity of stated demand for LTCI. Gender and age patterns suggest that information effects are heterogeneous: women start from lower willingness to pay but respond more strongly to information, while younger and older individuals appear more reactive than those in midlife. These differences point to informational and experiential mechanisms as key factors shaping how individuals perceive and value long-term care protection.

3. Information and WTP for LTCI

This section examines how information quantitively affects individuals' willingness to pay for long-term care insurance. We start by presenting the econometric specifications used to estimate treatment effects. Subsequently, we discuss how the provision of information influences both the intensive and extensive margins of WTP. The section concludes with a set of robustness checks assessing the consistency of the results.

3.1 Model Specification

To evaluate respondents' willingness to pay for long-term care insurance, we estimate two related models that share the same specification but differ in the definition of the dependent variable. The general empirical framework is given by

$$y_i = \beta_0 + \beta_1 G_{1i} + \beta_2 T_{1i} + \gamma \boldsymbol{X}_i + \varepsilon_i$$

where G_1 and T_1 denote the two informational treatments, and $\boldsymbol{X}$ is a vector of control variables capturing individual and household characteristics. The group G_2, which never receives any additional information, serves as the reference (control) category.

The intensive margin of WTP—the amount respondents are willing to pay—is analyzed using a Tobit model, which accounts for censoring at both the lower and upper bounds of the reported range. Respondents who are unwilling or undecided about paying are coded as zero, representing the left-censored limit of the distribution. Specifically, we set the lower bound at 0, the lowest and natural option in the survey, and the upper bound at 100, the highest option in the survey.[8] The extensive margin, which captures the probability of being willing to purchase LTCI, is modeled using a probit specification, where $y_i = 1$ if the respondent reports a positive WTP and $y_i = 0$ otherwise.

In both models, the coefficients β_1 and β_2 identify the effects of the first and second informational treatments relative to the control group. The first treatment (G_1) provides factual data and forecasts on long-term care needs and costs, while the second (T_1)—applied to a subset of respondents in G_1—adds information about the tax incentives associated with LTCI. The vector of controls $\boldsymbol{X}_i$ includes a rich set of individual and household characteristics to account for observable heterogeneity in preferences and socioeconomic conditions. Specifically, we control for age, gender, marital status, and family size, as well as educational attainment (high school and college dummies), and labor-market status (employed, self-employed, and retired). Economic conditions are captured by log household income and homeownership, while health insurance and other insurance coverage account for prior experience with private insurance products. We also include indicators for awareness of LTCI and exposure to long-term care situations, which may directly influence attitudes toward insurance, along with area fixed effects to control for regional heterogeneity.

3.2 WTP for LTCI: Intensive Margin

To examine how information affects the intensity of demand for LTCI, we estimate Tobit models of respondents' stated WTP, accounting for censoring at both the lower and upper bounds of the reported range. The dependent variable measures the monthly premium respondents are willing to pay for LTCI. Individuals who were undecided about paying are excluded from this baseline analysis and later included in robustness checks, coded as zero to provide a conservative lower bound. Because treatment assignment has been shown to be random in the balance tests, as shown in Table 3, the estimated coefficients can be

[8] As a robustness check, we also re-estimate the same specifications using an upper censoring limit of 125 for the WTP variable. The results remain virtually unchanged, confirming that our findings are not sensitive to the choice of the upper bound.

interpreted as causal effects. The group G_2 serves as the reference category, so the coefficients on G_1 and T_1 measure deviations from the control mean WTP of about €23.5.

The results reported in Table 8 reveal a strong and stable effect of the first informational treatment, G_1, while T_1—introducing information on tax advantages—has no significant impact. In the baseline model with only area fixed effects (column 1), factual information on long-term care risks and costs increases WTP by roughly €3.6, significant at the 5% level, equivalent to about a 15% increase relative to the control mean. This coefficient remains remarkably stable across specifications (2) to (5), where demographic, educational, and employment characteristics are progressively added, suggesting that the effect is not driven by observable differences across treatment groups. Once income, insurance status, and attitudinal variables are included in columns (6) and (7), the coefficient declines modestly to around €3, indicating that some of the initial effect operates through channels correlated with awareness, income, and prior exposure to insurance. The second treatment, T_1, is consistently small, negative, and statistically not significant throughout, implying that once respondents are informed about the need and cost of long-term care, additional details about tax incentives have no measurable influence on their WTP.

The evolution of the control variables across specifications provides a coherent picture of the determinants of LTCI demand. Age enters positively and becomes significant from column (2) onward, with an estimated effect of roughly €0.17 per year once the full set of covariates is included, consistent with the notion that perceived dependency risk rises with age.[9] Gender shows a large and robust effect: men are willing to pay between €5 and €7 more than women, a difference that remains significant across all specifications, reflecting both higher income and stronger financial engagement. Marital status is positively associated with WTP in early models, around €3, but loses significance once income and homeownership are introduced, suggesting that the higher valuation among married respondents is largely explained by household economic resources. Family size has a positive and significant association with WTP in intermediate specification, about €1.5 per household member, but decreases and becomes statistically not significant in the richer models, indicating that the effect operates mainly through income and housing. Education exerts a strong, persistent influence. Individuals with a high school diploma report WTP levels about €5 higher than those with only primary education, and those with a college degree pay roughly €9–10 more. These coefficients decrease slightly as income and insurance variables are added, but remain statistically significant, highlighting the importance of financial literacy and information-processing capacity in shaping LTCI valuation.

[9] It is important to emphasize that the analysis of the intensive margin, as elicited by $G_1$and T_1, captures shifts on the demand side. For example, Table 8 in this section—as well as Tables 10 and 12 in Section 3.4.1—indicate a higher WTP conditional on age. Nevertheless, insurance companies may not be willing to supply coverage at the corresponding demanded price, implying a potential mismatch between demand and supply conditions.

Labor-market status also matters. Both employed and self-employed respondents display higher WTP than the non-employed. For the employed, the coefficient starts around €7 and decreases to about €2–3 once income is controlled for, suggesting that part of the effect operates through higher earnings. The self-employed consistently exhibit the highest valuations, with coefficients between €4 and €8, possibly reflecting stronger risk awareness and greater autonomy in managing personal financial protection. Retirement initially shows a positive coefficient of about €5–6, but this effect disappears once income is introduced, indicating that retirees' higher WTP is driven by income differences rather than retirement status per se. Indeed, economic resources are strong predictors of WTP. A one-unit increase in log income raises WTP by approximately €7–10, among the largest effects in the model.

Homeownership is also positively associated with WTP—about €3 in the full specification—though the coefficient loses significance once financial and insurance variables are included, likely because homeownership proxies for wealth captured elsewhere. Indicators of prior insurance experience and attitudes toward long-term care display some of the strongest effects in the model. Having health insurance increases WTP by around €5, while holding other private insurance products adds roughly €6. These variables capture familiarity with risk pooling and lower barriers to considering new insurance products. The inclusion of these controls slightly reduces the magnitude of the G_1 coefficient, confirming that part of the informational treatment's effect reflects pre-existing differences in insurance engagement. Finally, LTCI awareness and LTC exposure have large and highly significant effects: being aware of LTCI is associated with a roughly €11 higher WTP, and having direct experience with long-term care adds around €9. Their introduction in the final specification absorbs a portion of the G_1 coefficient, indicating that the treatment partly operates by enhancing these very dimensions—raising awareness and perceived exposure to dependency risk, which in turn drive valuation. Across all specifications, the coefficient on T_1 remains close to zero, confirming that fiscal framing has no marginal impact once factual information is provided.

The Tobit estimates indicate that exposure to factual information, G_1, causally increases WTP for LTCI by about €3 per month, or roughly 15% relative to the control mean, an effect that is both stable and economically meaningful. The detailed evolution of coefficients across columns shows that the main drivers of WTP are age, education, income, and prior insurance experience, and that the information treatment's effect largely operates by increasing awareness and salience of long-term care needs rather than shifting fundamental financial constraints or preferences.

3.3 WTP for LTCI: Extensive Margin

We next turn to the extensive margin, analyzing the probability that respondents express any willingness to pay for LTCI. To this end, we estimate probit models where the dependent variable equals 1 if WTP > 0 and 0 otherwise. The specification mirrors the Tobit framework

used for the intensive margin, allowing direct comparison between the determinants of the likelihood and the level of demand. The results, reported in Table 9, broadly confirm the patterns observed in the Tobit regressions, though the effects are smaller in magnitude. The first informational treatment consistently increases the probability of stating a positive WTP, whereas the second treatment shows an opposite pattern. In the baseline specification with only area fixed effects (column 1), receiving factual information raises the probability of expressing a positive WTP by roughly 9 percentage points relative to the control group. This effect is positive and stable across the subsequent specifications (columns 2–7), but its statistical significance declines as further controls are included, suggesting that the information treatment primarily affects the intensity of willingness to pay rather than the binary decision to insure. In contrast, T_1 displays a consistently negative and statistically significant effect throughout. The estimated marginal effect, ranging from about -0.13 to -0.15, implies that exposure to information on tax deductions slightly reduces the probability of insuring. While the data do not directly reveal the mechanism, we interpret this outcome as reflecting a possible misunderstanding or misperception of the fiscal incentive. The tax treatment may have introduced complexity or uncertainty that respondents did not fully process, leading to a lower stated willingness to participate. As we show later in Section 3.4.2, this negative effect is not stable across alternative model specifications, supporting the view that it likely stems from misinterpretation rather than a true deterrent effect.

The inclusion of covariates across columns (2) to (7) reveals consistent patterns in the determinants of participation. Age enters positively and becomes significant early on, confirming that older individuals—those closer to the risk of dependency—are more likely to express a positive WTP. Gender effects are large and robust: men are about 10 to 13 percentage points more likely than women to report willingness to insure. Married respondents also show higher participation probabilities in the initial specifications (roughly 7–8 percentage points higher), though this association weakens once income and employment are included. Family size has a positive coefficient of around 3 percentage points per additional household member, but the effect loses significance in the full model. Educational attainment remains a strong predictor of willingness to insure. Respondents with a college degree are about 15–20 percentage points more likely to report positive WTP compared to those with primary education, even after controlling for income and labor-market status. In line with the estimates for the intensive margin, labor-market participation turns out to be crucial at this stage: both the employed and self-employed display significantly higher probabilities of insuring, with marginal effects between 7 and 10 percentage points, while retirees exhibit weaker or insignificant associations once income is added. Economic and insurance-related factors further refine the picture. Higher income increases the probability of insuring by roughly 10 percentage points per log point of income, one of the strongest predictors in the model. Homeownership is positively associated with willingness to insure, though the effect becomes less precise when other wealth proxies are

introduced. Private health insurance and other insurance coverage each add roughly 10 percentage points to the probability of expressing a positive WTP, confirming that prior insurance experience and financial engagement foster participation in LTCI markets. Finally, LTCI awareness and direct exposure to long-term care situations emerge as dominant factors. Awareness increases the probability of insuring by about 25 percentage points, while exposure adds another 20 points, highlighting the central role of familiarity and personal relevance. Their inclusion in the final specification reduces the magnitude of the G_1 coefficient slightly, suggesting that part of the informational treatment's impact works by enhancing awareness and salience.

The Probit estimates reinforce the evidence from the intensive-margin analysis: G_1 modestly increases the share of individuals willing to insure, while the tax treatment produces a small but negative response—likely due to misunderstanding of its content rather than genuine discouragement. The subsequent robustness checks confirm that this negative effect does not persist.

3.4 Robustness

We assess the robustness of our main findings across alternative clusters and sample definitions. Specifically, we re-estimate the Tobit and Probit models including respondents who were previously coded as undecided, and explore whether the effects of information treatments vary across key demographic and socioeconomic groups. The results confirm that the main conclusions for the intensive margin remain stable across most specifications, while the evidence for the extensive margin is less consistent and more sensitive to modeling choices, reinforcing the interpretation of informational misunderstanding.

3.4.1 Intensive Margin

Tables 10–14 explore how the effect of information varies across groups and specifications, shedding light on the mechanisms behind differences in respondents' willingness to pay. While the direction of the effect remains positive throughout, its magnitude shifts with baseline characteristics such as prior awareness, financial position, and market participation.

Starting from Table 10, where undecided respondents are reintroduced and coded as zero, the estimated coefficient begins around €2.7 and gradually falls to roughly €2.3 once LTCI awareness and exposure are included. This downward shift reflects the mechanical overweighting of zero responses, which biases the coefficient toward zero, as well as the strong explanatory power of these attitudinal controls. The estimates therefore represent a conservative lower bound rather than evidence of instability.

The gender split in Table 11 shows that men have a higher baseline willingness to pay, consistent with higher income and greater insurance participation, yet the information treatment raises WTP by a similar amount for both sexes—around €3. Because women start

from a lower baseline, this comparable absolute effect narrows the initial gap, suggesting that the information treatment helps offset pre-existing differences in awareness and perceived relevance of long-term care protection.

Differences across age cohorts in Table 12 align closely with life-cycle and market-access considerations. Younger individuals (below 35) show low WTP levels and limited responsiveness, as long-term care risks remain distant and competing financial priorities dominate. The effect peaks among middle-aged respondents, who combine financial flexibility with growing concern about dependency risks, often reinforced by caregiving responsibilities for older relatives. Among older individuals, willingness to pay is generally higher in absolute terms but less affected by the treatment. This muted response likely reflects a supply-side constraint: many older adults face difficulties accessing affordable long-term care insurance due to higher perceived risk, making new information less actionable despite genuine interest. A similar gradient appears by education level in Table 13. The effect of information is more pronounced among respondents with secondary or tertiary education, likely because they face lower information and search costs, greater confidence in formal financial instruments, and clearer understanding of the policy's long-term implications. For those with only primary schooling, limited familiarity with private insurance and financial planning may hinder the translation of new information into an expressed willingness to pay.

Finally, Table 14 contrasts respondents by health-insurance status. Interestingly, the effect tends to be statistically significant among the uninsured—who appear more responsive because the message increases their perceived vulnerability—while it weakens among those already insured. For the latter group, the smaller and often insignificant coefficient likely reflects saturation rather than indifference: they already hold protection and therefore have less scope to adjust their stated willingness to pay in response to new information.

Across most dimensions, the informational treatment consistently raises valuations but with varying intensity depending on prior conditions. It is strongest among groups with both the capacity and motivation to act (middle-aged, better educated, uninsured) and among those for whom information reduces prior uncertainty (women). The evidence thus points to information as a corrective force—one that narrows pre-existing gaps in awareness and perceived exposure while revealing the structural limits faced by older or already covered individuals.

3.4.2 Extensive Margin

Extending the analysis to the extensive margin, we now examine whether information influences the probability of being willing to purchase LTCI. This shift in focus allows a direct comparison with the previous results on the intensive margin, highlighting whether information not only changes valuations but also affects the decision to insure.

Mirroring Table 10-14, the estimates reported in Tables 15–19 reveal a clear contrast. While the informational treatments consistently raise WTP amounts in the Tobit specifications, their effect on the binary willingness to purchase is far less robust. In Table 15, the first information treatment maintains a positive but modest coefficient, often losing statistical significance once controls are added, whereas the second treatment again has no measurable impact. The attenuation of the coefficients when undecided respondents are included (coded as zero, as in Table 10) further illustrates that the extensive margin is much less responsive to information than the intensive one.

Heterogeneity patterns offer further insight. In Table 16, gender differences persist: men retain a higher baseline probability of insuring, while women show a slightly stronger relative increase in response to information, which narrows the initial gap but does not eliminate it. Table 17 shows that middle-aged individuals remain the most responsive group—likely because the information aligns with their rising awareness of dependency risk and manageable financial horizon—whereas younger respondents remain largely indifferent, and older ones face strong supply-side constraints, limiting the scope for behavioral adjustment even when awareness rises. Education-based differences in Table 18 continue to point toward the role of financial familiarity and trust: individuals with higher education display a clearer, though still modest, positive response to information, while for the less educated, the effect remains weak. Finally, Table 19 shows that the response is more pronounced among the uninsured, who feel more exposed after receiving the information, while it becomes small and statistically insignificant among the already insured, likely because they already possess coverage and thus have limited room to adjust their decision.

The extensive-margin results are not robust across specifications or subsamples, indicating that information alone is insufficient to shift individuals' binary decision to insure. In other words, while the treatments clearly affect how much individuals are willing to pay, they do not meaningfully alter whether individuals are willing to purchase coverage in the first place. This asymmetry suggests that awareness and understanding can raise valuations but are rarely enough to overcome financial constraints, inertia, or skepticism toward private long-term care insurance.

3.5 Potential Funding Capacity

To complement the micro-level analysis of willingness to pay, we provide a back-of-the-envelope calculation of the potential aggregate funding capacity implied by our estimates. Given that our data are representative of the Italian population aged 18–75, as shown by Guiso and Jappelli (2024a), and that Italian National Institute of Statistics (ISTAT) reports

approximately 43 million individuals in that age range, we can extrapolate unconditional average contributions to the national level.[10]

Assuming that individuals were hypothetically required to contribute according to their stated preferences—for instance, through a mandatory public scheme we can derive the implied aggregate fund before and after the information treatments. Since effects on the extensive margin, whether to contribute, are generally not robust T_1 is not statistically significant, we focus on G_1 and on the intensive margin, how much to contribute, which offers a reasonable approximation of the population's effective willingness to pay.

We then compare these implied private contributions with both the net family expenses for LTC and the current level of public LTC expenditure, as reported by the Italian Ministry of Economy and Finance (MEF, 2025).[11] Specifically, households spend approximately €85 billion on LTC, whereas, according to MEF projections, total public LTC spending amounts to 1.61% of GDP—equivalent to about €35 billion in 2024—with the majority directed to healthcare services (0.64% of GDP) and attendance allowances (0.70%).

By scaling our average contribution levels to the national population, we can thus quantify the potential private funding pool that would emerge if individuals were mandated to contribute in line with their preferences. This provides a useful benchmark for understanding the magnitude of voluntary contributions relative to existing public spending and for evaluating the fiscal relevance of private willingness to pay in a possible public-private LTC financing reform. Quantitatively, before the G_1 treatment, the implied annual funding capacity amounts to approximately €12.1 billion, obtained by multiplying the average monthly unconditional WTP of €23.5 by the 43 million individuals aged 18–75 and by 12 months (23.5 × 43 million × 12). After exposure to the information treatment, three alternative approximations can be considered. The first relies on the uncontrolled mean difference reported in Table 1, yielding an average WTP of €25.4, and thus an aggregate capacity of about €13.1 billion (25.4 × 43 million × 12). The second augments the baseline average by the conservative estimate from Table 10, which considers a higher share of zeros, i.e., a larger share of respondents unwilling to buy, and finds a €2.2 increase in WTP, resulting in an implied fund of roughly €13.3 billion (25.7 × 43 million × 12). The third uses the fully specified Tobit estimate from Table 8, indicating a €3 increase in WTP, which translates into a potential capacity of approximately €13.7 billion (26.5 × 43 million × 12). Across all specifications, the aggregate potential fund increases from around €12.1 billion to between

[10] By using unconditional averages, we rely on minimal information requirements and solely on representativeness, which is satisfied as shown in Table 3. However, this approach does not allow us to identify each individual's WTP conditional on specific characteristics.

[11] See https://www.itinerariprevidenziali.it/site/home/ricerche/rapporto-sul-bilancio-del-sistema-previdenziale-italiano.html and https://www.rgs.mef.gov.it/VERSIONE-I/attivita_istituzionali/monitoraggio/spesa_pensionistica/.

€13.1 and €13.7 billion,[12] equivalent to roughly 15% of family expenses and one-third of current public expenditure, corresponding to an 8–12% rise in potential annual contributions. These figures indicate that informational triggers alone can meaningfully expand the pool of private resources available for long-term care financing in Italy and complementing existing public expenditure, showing that private coverage can effectively coexist with the current public system, even without fiscal incentives.

4. Conclusions

This paper examines how information influences individuals' WTP for LTCI using a randomized experiment embedded in the Italian Survey of Consumer Expectations. The design ensures causal identification, as the random allocation of respondents across treatment arms rules out self-selection and confounding factors.

The analysis reveals a clear and robust pattern: information on long-term care risks and costs, G_1, significantly increases the amount individuals are willing to pay for coverage, while the fiscal message, T_1, has no sizeable effect. On the intensive margin, G_1 raises average WTP by about €3, corresponding to an increase of roughly 15% relative to the untreated group. By contrast, the second informational intervention does not affect either the level or the likelihood of positive WTP, suggesting that the fiscal component was likely misunderstood or perceived as too abstract. The extensive-margin results are also less consistent, as treatment effects weaken once additional controls or undecided respondents are introduced. This reinforces the interpretation that the intervention primarily affects how much individuals are willing to contribute, rather than whether they participate at all. Robustness checks confirm these findings. The main effect survives alternative model assumptions, the inclusion of censored observations, and subsample analyses by gender, age, education, and health-insurance status. Some heterogeneity emerges: women, younger respondents, and the uninsured display larger percentage increases in WTP, indicating that information tends to reduce knowledge gaps across demographic groups.

Using these individual estimates to approximate aggregate outcomes, the mean monthly WTP implies an annual potential funding capacity of about €12.1 billion under the control scenario. After the information intervention, the capacity rises to between €13.1 and €13.7 billion, corresponding to an 8–12% increase. Although purely hypothetical, these figures suggest that factual awareness alone could substantially expand the pool of private resources available for long-term care financing. When compared with family expenses for LTC, around €85 billion, and public LTC expenditure—currently around €35 billion, or 1.6% of Italian GDP—the potential private contribution represents a meaningful, though not sufficient, complement to existing spending.

[12] As specified above, in Section 2.3, the baseline average is conservative. This does not affect the absolute differences in potential funding but sets a lower bound, given the estimates, for their values.

The findings indicate that clear and accessible information can effectively enhance individuals' valuation of long-term care coverage, while more complex or technical messages, such as those related to fiscal incentives, have limited behavioral impact. Improving awareness of long-term care needs could therefore play a central role in strengthening both private preparedness and the financial sustainability of the long-term care system.

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Table 1: Summary Statistics.

Variable	Obs.	Mean	Std. Dev.	Min	Max
Age	5,000	48.85	13.83	18	75
Male	5,000	0.481	0.500	0	1
Married	5,000	0.580	0.494	0	1
Family size	5,000	2.770	1.133	1	6
High school	5,000	0.506	0.500	0	1
College	5,000	0.256	0.436	0	1
Center	5,000	0.200	0.400	0	1
South	5,000	0.342	0.474	0	1
Employed	5,000	0.478	0.500	0	1
Self-employed	5,000	0.086	0.280	0	1
Retired	5,000	0.179	0.383	0	1
(log) Income	5,000	7.638	0.523	6.62	9.90
Homeowner	5,000	0.777	0.416	0	1
Health insurance	5,000	0.252	0.434	0	1
Other insurance	5,000	0.484	0.500	0	1
LTCI aware	5,000	0.364	0.481	0	1
LTC exposure	5,000	0.117	0.322	0	1
WTP LTCI	5,000	24.44	28.70	0	100
WTP LTCI, Yes	5,000	0.690	0.463	0	1

Table 2: Means by Treatment Group.

Variable	All	G_2	G_1	T_1
Age	48.85	48.85	48.85	48.55
Male	0.481	0.483	0.479	0.475
Married	0.580	0.590	0.571	0.564
Family size	2.770	2.76	2.78	2.79
High school	0.506	0.509	0.503	0.499
College	0.256	0.261	0.251	0.240
Center	0.200	0.194	0.206	0.202
South	0.342	0.350	0.333	0.335
Employed	0.478	0.483	0.473	0.468
Self-employed	0.086	0.088	0.084	0.081
Retired	0.179	0.179	0.179	0.167
(log) Income	7.638	7.64	7.64	7.63
Homeowner	0.777	0.783	0.772	0.764
Health insurance	0.252	0.250	0.254	0.241
Other insurance	0.484	0.487	0.483	0.480
LTCI aware	0.364	0.346	0.382	0.375
LTC exposure	0.117	0.124	0.110	0.115
WTP LTCI	24.44	23.52	25.36	25.21
WTP LTCI, Yes	0.690	0.691	0.689	0.677

Table 3: Balance Tests, Probit Regressions.

	$\Pr(x_i \in G_1)$	$\Pr(x_i \in T_1)$	$\Pr(x_i \in T_1 \mid x_i \in G_1)$
Age	-0.000	-0.001	-0.002
	(0.002)	(0.002)	(0.003)
Male	-0.004	0.013	0.025
	(0.041)	(0.045)	(0.059)
Married	-0.119**	-0.095*	-0.030
	(0.046)	(0.050)	(0.066)
Family size	0.018	0.017	0.007
	(0.020)	(0.022)	(0.028)
High school	-0.040	-0.081	-0.090
	(0.050)	(0.053)	(0.071)
College	-0.062	-0.114*	-0.121
	(0.061)	(0.066)	(0.088)
Centre	0.006	-0.400	0.447
	(0.339)	(0.365)	(0.479)
South	-0.087	-0.468	0.443
	(0.331)	(0.357)	(0.470)
Employed	-0.060	-0.100*	-0.107
	(0.054)	(0.058)	(0.077)
Self-employed	-0.021	-0.113	-0.171
	(0.080)	(0.087)	(0.113)
Retired	0.033	-0.092	-0.176*
	(0.076)	(0.081)	(0.107)
(log) Income	0.018	-0.005	-0.027
	(0.045)	(0.049)	(0.064)
Homeowner	-0.047	-0.013	0.032
	(0.050)	(0.054)	(0.070)
Health insurance	0.033	-0.057	-0.119*
	(0.049)	(0.054)	(0.068)
Other insurance	0.003	0.020	0.032
	(0.044)	(0.048)	(0.063)
LTCI aware	0.107***	0.024	-0.066
	(0.041)	(0.045)	(0.058)
LTC exposure	-0.082	0.022	0.116
	(0.060)	(0.066)	(0.087)
Area FE	Yes	Yes	Yes
Observations	4,181	4,181	2,084

Robust standard errors in parentheses. *** p < 0.01, ** p < 0.05, * p < 0.10

Table 4: Means, by Gender and Treatment Group.

		Male				Female		
Variable	All	G_2	G_1	T_1	All	G_2	G_1	T_1
Age	49.38	49.39	49.36	49.21	48.37	48.35	48.39	47.95
Married	0.588	0.605	0.570	0.550	0.573	0.575	0.571	0.577
Family size	2.71	2.72	2.70	2.73	2.83	2.79	2.86	2.86
High school	0.501	0.502	0.500	0.499	0.511	0.515	0.507	0.499
College	0.264	0.270	0.257	0.239	0.249	0.253	0.245	0.242
Center	0.199	0.197	0.202	0.195	0.201	0.192	0.210	0.209
South	0.340	0.357	0.324	0.318	0.343	0.344	0.342	0.352
Employed	0.556	0.565	0.547	0.526	0.406	0.407	0.405	0.416
Self-employed	0.107	0.105	0.109	0.111	0.067	0.071	0.062	0.055
Retired	0.233	0.228	0.239	0.235	0.129	0.133	0.124	0.105
(log) Income	7.698	7.717	7.680	7.675	7.583	7.563	7.602	7.581
Homeowner	0.791	0.797	0.784	0.780	0.765	0.770	0.760	0.750
Health insurance	0.294	0.301	0.287	0.277	0.213	0.203	0.224	0.209
Other insurance	0.521	0.531	0.512	0.516	0.451	0.445	0.456	0.447
LTCI aware	0.342	0.313	0.373	0.397	0.384	0.377	0.391	0.356
LTC exposure	0.146	0.153	0.140	0.151	0.090	0.097	0.083	0.082
WTP LTCI	27.47	27.34	27.60	27.29	21.64	19.95	23.31	23.33
WTP LTCI, Yes	0.722	0.731	0.714	0.691	0.660	0.654	0.666	0.664

Table 5: Means, by Age Cohort and Treatment Group.

	Age ≤ 34				34 < Age < 65				Age ≥ 65			
Variable	All	G_2	G_1	T_1	All	G_2	G_1	T_1	All	G_2	G_1	T_1
Age	29.21	29.27	29.16	29.16	50.95	50.93	50.98	50.80	68.98	69.15	68.81	68.85
Male	0.466	0.468	0.465	0.465	0.463	0.466	0.460	0.452	0.582	0.579	0.585	0.602
Married	0.297	0.311	0.282	0.260	0.640	0.653	0.627	0.631	0.739	0.731	0.747	0.731
Family size	2.90	2.92	2.89	2.85	2.85	2.83	2.87	2.91	2.19	2.19	2.19	2.17
High school	0.458	0.475	0.441	0.469	0.509	0.507	0.511	0.496	0.567	0.571	0.563	0.561
College	0.478	0.457	0.499	0.484	0.202	0.217	0.187	0.172	0.165	0.163	0.168	0.175
Center	0.181	0.157	0.205	0.201	0.209	0.211	0.207	0.198	0.189	0.175	0.205	0.222
South	0.388	0.390	0.386	0.392	0.341	0.347	0.336	0.330	0.275	0.305	0.244	0.269
Employed	0.670	0.681	0.659	0.670	0.511	0.516	0.506	0.488	0.039	0.039	0.040	0.053
Self-employed	0.083	0.077	0.089	0.062	0.101	0.104	0.097	0.101	0.025	0.030	0.020	0.018
Retired	0	0	0	0	0.092	0.088	0.096	0.083	0.840	0.850	0.830	0.830
(log) Income	7.698	7.698	7.697	7.700	7.603	7.604	7.602	7.586	7.709	7.694	7.726	7.696
Homeowner	0.700	0.691	0.710	0.736	0.785	0.797	0.773	0.755	0.860	0.859	0.861	0.854
Health insurance	0.314	0.322	0.305	0.311	0.252	0.252	0.253	0.229	0.157	0.133	0.182	0.187
Other insurance	0.463	0.436	0.490	0.491	0.485	0.499	0.472	0.467	0.516	0.507	0.526	0.526
LTCI aware	0.304	0.289	0.320	0.326	0.377	0.359	0.394	0.385	0.398	0.377	0.420	0.409
LTC exposure	0.129	0.133	0.126	0.139	0.109	0.122	0.097	0.101	0.135	0.125	0.145	0.140
WTP LTCI	24.24	22.78	25.73	27.47	24.04	23.74	24.34	23.70	26.53	23.63	29.50	28.74
WTP LTCI, Yes	0.717	0.724	0.710	0.736	0.685	0.695	0.676	0.652	0.670	0.623	0.719	0.696

Table 6: Means, by Education and Treatment Group.

	Primary				Secondary				Tertiary			
Variable	All	G_2	G_1	T_1	All	G_2	G_1	T_1	All	G_2	G_1	T_1
Age	53.34	53.41	53.28	53.14	49.90	49.82	49.99	49.24	42.61	42.97	42.24	42.15
Male	0.475	0.477	0.473	0.479	0.476	0.476	0.475	0.475	0.495	0.499	0.491	0.472
Married	0.654	0.681	0.629	0.613	0.583	0.591	0.575	0.557	0.505	0.507	0.504	0.525
Family size	2.77	2.82	2.72	2.77	2.76	2.74	2.78	2.78	2.80	2.75	2.85	2.85
Center	0.143	0.124	0.161	0.150	0.209	0.210	0.207	0.213	0.237	0.225	0.249	0.236
South	0.307	0.340	0.276	0.294	0.343	0.336	0.350	0.349	0.372	0.387	0.356	0.352
Employed	0.376	0.366	0.385	0.402	0.443	0.457	0.430	0.422	0.641	0.637	0.646	0.635
Self-employed	0.064	0.059	0.068	0.067	0.078	0.081	0.075	0.067	0.122	0.126	0.118	0.126
Retired	0.229	0.244	0.215	0.196	0.194	0.190	0.199	0.184	0.102	0.100	0.105	0.100
(log) Income	7.476	7.484	7.468	7.463	7.619	7.620	7.618	7.604	7.827	7.804	7.851	7.848
Homeowner	0.712	0.746	0.681	0.672	0.799	0.791	0.807	0.790	0.795	0.799	0.789	0.811
Health insurance	0.180	0.176	0.184	0.190	0.237	0.233	0.241	0.227	0.348	0.349	0.348	0.326
Other insurance	0.420	0.439	0.402	0.414	0.488	0.496	0.479	0.466	0.540	0.510	0.571	0.581
LTCI aware	0.354	0.362	0.346	0.334	0.370	0.346	0.394	0.403	0.363	0.332	0.394	0.362
LTC exposure	0.067	0.080	0.055	0.049	0.110	0.110	0.110	0.123	0.178	0.191	0.164	0.169
WTP LTCI	20.51	20.88	20.17	20.60	25.22	23.58	26.87	26.31	26.54	25.70	27.41	27.92
WTP LTCI, Yes	0.659	0.666	0.654	0.635	0.682	0.676	0.689	0.675	0.734	0.743	0.724	0.724

Table 7: Means, by Health Insurance Status and Treatment Group.

	No Health Insurance				Health Insurance			
Variable	All	G_2	G_1	T_1	All	G_2	G_1	T_1
Age	49.72	49.80	49.64	49.29	46.28	46.01	46.54	46.20
Male	0.454	0.450	0.458	0.453	0.560	0.581	0.540	0.546
Married	0.565	0.574	0.556	0.555	0.625	0.637	0.613	0.593
Family size	2.713	2.685	2.742	2.753	2.938	2.981	2.896	2.927
High school	0.516	0.521	0.512	0.508	0.476	0.474	0.479	0.470
College	0.223	0.227	0.219	0.214	0.354	0.365	0.343	0.325
Center	0.191	0.179	0.204	0.185	0.227	0.240	0.214	0.255
South	0.373	0.389	0.356	0.365	0.250	0.234	0.266	0.242
Employed	0.412	0.410	0.414	0.409	0.674	0.701	0.647	0.652
Self-employed	0.088	0.091	0.085	0.087	0.080	0.078	0.082	0.063
Retired	0.202	0.206	0.199	0.183	0.110	0.098	0.121	0.116
(log) Income	7.551	7.547	7.555	7.547	7.898	7.909	7.888	7.875
Homeowner	0.761	0.764	0.758	0.748	0.825	0.838	0.811	0.815
Other insurance	0.401	0.406	0.397	0.397	0.733	0.730	0.737	0.742
LTCI aware	0.350	0.337	0.364	0.361	0.406	0.374	0.436	0.421
LTC exposure	0.076	0.080	0.073	0.082	0.238	0.259	0.217	0.219
WTP LTCI	22.15	21.36	22.95	22.73	31.23	30.00	32.44	33.03
WTP LTCI, Yes	0.652	0.654	0.649	0.637	0.804	0.802	0.806	0.801

Table 8: Intensive Margin, Tobit Regressions.

WTP LTCI	(1)	(2)	(3)	(4)	(5)	(6)	(7)
G_1	3.665**	3.763***	3.744***	3.711***	3.631**	3.447**	3.098**
	(1.463)	(1.452)	(1.442)	(1.439)	(1.430)	(1.422)	(1.397)
T_1	-1.627	-1.453	-1.139	-0.901	-0.803	-0.632	-0.568
	(1.723)	(1.714)	(1.700)	(1.698)	(1.683)	(1.664)	(1.641)
Age		0.088*	0.161***	0.172***	0.180***	0.186***	0.134**
		(0.049)	(0.051)	(0.061)	(0.060)	(0.060)	(0.059)
Male		7.138***	7.064***	5.154***	4.805***	4.309***	4.469***
		(1.188)	(1.181)	(1.246)	(1.236)	(1.226)	(1.211)
Married		3.657***	3.639***	3.523***	1.129	0.569	0.817
		(1.360)	(1.353)	(1.350)	(1.352)	(1.344)	(1.325)
Family size		1.245**	1.450**	1.586***	0.405	0.326	0.085
		(0.593)	(0.590)	(0.596)	(0.600)	(0.592)	(0.584)
High school			7.927***	7.510***	5.498***	5.287***	4.700***
			(1.448)	(1.448)	(1.447)	(1.437)	(1.409)
College			10.760***	9.155***	5.199***	4.441**	3.112*
			(1.689)	(1.727)	(1.753)	(1.742)	(1.728)
Employed				7.443***	3.935**	2.498	3.166**
				(1.564)	(1.617)	(1.610)	(1.595)
Self-employed				8.485***	5.605**	4.571*	4.323*
				(2.410)	(2.417)	(2.406)	(2.365)
Retired				5.646**	1.585	1.762	1.599
				(2.338)	(2.349)	(2.337)	(2.307)
(log) Income					10.686***	7.838***	7.825***
					(1.335)	(1.354)	(1.349)
Homeowner					2.800**	1.075	1.381
					(1.407)	(1.428)	(1.414)
Health insurance						7.123***	4.987***
						(1.393)	(1.406)
Other insurance						7.547***	6.408***
						(1.283)	(1.258)
LTCI aware							11.590***
							(1.196)
LTC exposure							9.130***
							(1.822)
Area FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Observations	4,181	4,181	4,181	4,181	4,181	4,181	4,181

Robust standard errors in parentheses. *** p < 0.01, ** p < 0.05, * p < 0.10

Table 9: Extensive Margin, Probit Regressions.

WTP LTCI, Yes	(1)	(2)	(3)	(4)	(5)	(6)	(7)
G_1	0.088	0.094*	0.094	0.090	0.091	0.088	0.069
	(0.057)	(0.057)	(0.057)	(0.058)	(0.058)	(0.058)	(0.060)
T_1	-0.148**	-0.150**	-0.144**	-0.133**	-0.132**	-0.126*	-0.124*
	(0.065)	(0.065)	(0.065)	(0.066)	(0.066)	(0.066)	(0.068)
Age		-0.003	-0.001	0.001	0.001	0.002	0.001
		(0.002)	(0.002)	(0.002)	(0.002)	(0.002)	(0.002)
Male		0.130***	0.126***	0.055	0.046	0.027	0.050
		(0.046)	(0.046)	(0.049)	(0.049)	(0.050)	(0.051)
Married		0.123**	0.121**	0.109**	0.052	0.029	0.029
		(0.054)	(0.054)	(0.054)	(0.056)	(0.056)	(0.057)
Family size		0.051**	0.057**	0.063***	0.037	0.037	0.035
		(0.024)	(0.024)	(0.024)	(0.025)	(0.025)	(0.025)
High school			0.089	0.073	0.023	0.012	-0.009
			(0.056)	(0.056)	(0.057)	(0.057)	(0.058)
College			0.252***	0.193***	0.100	0.066	0.034
			(0.069)	(0.070)	(0.072)	(0.073)	(0.074)
Employed				0.301***	0.225***	0.167***	0.198***
				(0.060)	(0.063)	(0.064)	(0.065)
Self-employed				0.287***	0.226**	0.202**	0.199**
				(0.094)	(0.095)	(0.096)	(0.098)
Retired				0.147*	0.058	0.068	0.055
				(0.085)	(0.088)	(0.089)	(0.092)
(log) Income					0.240***	0.125**	0.121**
					(0.055)	(0.057)	(0.060)
Homeowner					0.089	0.022	0.028
					(0.056)	(0.057)	(0.058)
Health insurance						0.408***	0.352***
						(0.064)	(0.067)
Other insurance						0.272***	0.239***
						(0.051)	(0.052)
LTCI aware							0.512***
							(0.054)
LTC exposure							0.286***
							(0.088)
Area FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Observations	4,181	4,181	4,181	4,181	4,181	4,181	4,181

Robust standard errors in parentheses. *** p < 0.01, ** p < 0.05, * p < 0.10

Table 10: Intensive Margin, Tobit Regressions, with Undecided.

WTP LTCI	(1)	(2)	(3)	(4)	(5)	(6)	(7)
G_1	2.756*	2.810*	2.807*	2.802*	2.700*	2.560*	2.369
	(1.560)	(1.549)	(1.541)	(1.535)	(1.528)	(1.517)	(1.489)
T_1	-1.161	-1.025	-0.717	-0.437	-0.362	-0.223	-0.345
	(1.832)	(1.824)	(1.813)	(1.809)	(1.798)	(1.778)	(1.752)
Age		0.001	0.075	0.105	0.109*	0.116*	0.056
		(0.052)	(0.054)	(0.065)	(0.064)	(0.064)	(0.063)
Male		9.196***	9.069***	6.394***	6.079***	5.459***	5.424***
		(1.271)	(1.265)	(1.333)	(1.326)	(1.314)	(1.297)
Married		4.671***	4.685***	4.550***	2.457*	1.757	1.907
		(1.443)	(1.437)	(1.434)	(1.440)	(1.432)	(1.409)
Family size		1.180*	1.376**	1.554**	0.444	0.337	0.129
		(0.626)	(0.623)	(0.628)	(0.636)	(0.627)	(0.616)
High school			7.318***	6.757***	4.973***	4.535***	3.718**
			(1.551)	(1.549)	(1.553)	(1.540)	(1.508)
College			10.886***	8.623***	5.047***	4.062**	2.200
			(1.813)	(1.850)	(1.882)	(1.868)	(1.848)
Employed				10.335***	7.241***	5.670***	6.356***
				(1.668)	(1.719)	(1.714)	(1.694)
Self-employed				11.831***	9.262***	8.315***	7.828***
				(2.561)	(2.571)	(2.552)	(2.505)
Retired				6.795***	3.208	3.398	3.361
				(2.471)	(2.495)	(2.485)	(2.442)
(log) Income					9.684***	6.469***	6.479***
					(1.412)	(1.432)	(1.420)
Homeowner					2.478	0.688	1.195
					(1.509)	(1.529)	(1.513)
Health insurance						8.860***	6.079***
						(1.505)	(1.511)
Other insurance						8.107***	6.626***
						(1.374)	(1.345)
LTCI aware							12.289***
							(1.282)
LTC exposure							13.941***
							(1.953)
Area FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Observations	5,000	5,000	5,000	5,000	5,000	5,000	5,000

Robust standard errors in parentheses. *** p < 0.01, ** p < 0.05, * p < 0.10

Table 11: Intensive Margin, Tobit Regressions, by Gender.

WTP LTCI	Male	Female
G_1	2.295	5.107***
	(2.201)	(1.917)
T_1	-2.964	-0.391
	(2.605)	(2.263)
Area FE	Yes	Yes
Observations	2,063	2,118

Robust standard errors in parentheses. *** p < 0.01, ** p < 0.05, * p < 0.10

Table 12: Intensive Margin, Tobit Regressions, by Age Cohort.

WTP LTCI	Age ≤ 34	34 < Age < 65	65 ≤ Age
G_1	-0.905	3.831**	10.112**
	(2.793)	(1.850)	(4.305)
T_1	5.174	-3.723*	-2.387
	(3.332)	(2.187)	(4.991)
Area FE	Yes	Yes	Yes
Observations	924	2,668	589

Robust standard errors in parentheses. *** p < 0.01, ** p < 0.05, * p < 0.10

Table 13: Intensive Margin, Tobit Regressions, By Education.

WTP LTCI	Primary	Secondary	Tertiary
G_1	-0.379	6.755***	1.420
	(2.643)	(2.224)	(2.666)
T_1	-0.191	-3.017	0.934
	(3.066)	(2.617)	(3.167)
Area FE	Yes	Yes	Yes
Observations	981	2,106	1,094

Robust standard errors in parentheses. *** p < 0.01, ** p < 0.05, * p < 0.10

Table 14: Intensive Margin, Tobit Regressions, by Health Insurance Status.

WTP LTCI	No Health Insurance	Health Insurance
G_1	3.639**	2.451
	(1.718)	(2.710)
T_1	-2.481	2.612
	(2.012)	(3.186)
Area FE	Yes	Yes
Observations	3,079	1,102

Robust standard errors in parentheses. *** p < 0.01, ** p < 0.05, * p < 0.10

Table 15: Extensive Margin, Probit Regressions, with Undecided.

WTP LTCI, Yes	(1)	(2)	(3)	(4)	(5)	(6)	(7)
G_1	0.028	0.030	0.030	0.028	0.027	0.025	0.019
	(0.046)	(0.046)	(0.046)	(0.046)	(0.046)	(0.046)	(0.047)
T_1	-0.071	-0.072	-0.067	-0.059	-0.058	-0.055	-0.060
	(0.052)	(0.053)	(0.053)	(0.053)	(0.053)	(0.053)	(0.054)
Age		-0.005***	-0.003*	-0.001	-0.001	-0.001	-0.002
		(0.002)	(0.002)	(0.002)	(0.002)	(0.002)	(0.002)
Male		0.186***	0.183***	0.105***	0.100**	0.083**	0.088**
		(0.037)	(0.037)	(0.040)	(0.040)	(0.040)	(0.041)
Married		0.123***	0.123***	0.115***	0.085*	0.064	0.066
		(0.043)	(0.043)	(0.044)	(0.045)	(0.045)	(0.045)
Family size		0.030	0.035*	0.041**	0.024	0.022	0.021
		(0.019)	(0.019)	(0.019)	(0.020)	(0.020)	(0.020)
High school			0.059	0.043	0.016	-0.002	-0.026
			(0.046)	(0.046)	(0.047)	(0.047)	(0.047)
College			0.193***	0.126**	0.073	0.042	-0.006
			(0.056)	(0.057)	(0.059)	(0.059)	(0.060)
Employed				0.317***	0.274***	0.233***	0.258***
				(0.049)	(0.051)	(0.051)	(0.052)
Self-employed				0.328***	0.292***	0.280***	0.276***
				(0.077)	(0.078)	(0.078)	(0.078)
Retired				0.156**	0.106	0.114	0.116
				(0.069)	(0.071)	(0.072)	(0.072)
(log) Income					0.138***	0.046	0.043
					(0.043)	(0.044)	(0.045)
Homeowner					0.051	0.004	0.018
					(0.046)	(0.047)	(0.048)
Health insurance						0.315***	0.251***
						(0.049)	(0.051)
Other insurance						0.208***	0.170***
						(0.042)	(0.042)
LTCI aware							0.350***
							(0.041)
LTC exposure							0.427***
							(0.070)
Area FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Observations	5,000	5,000	5,000	5,000	5,000	5,000	5,000

Robust standard errors in parentheses. *** p < 0.01, ** p < 0.05, * p < 0.10

Table 16: Extensive Margin, Probit Regressions, by Gender.

WTP LTCI, Yes	Male	Female
G_1	0.115	0.068
	(0.085)	(0.078)
T_1	-0.265***	-0.044
	(0.095)	(0.090)
Area FE	Yes	Yes
Observations	2,063	2,118

Robust standard errors in parentheses. *** p < 0.01, ** p < 0.05, * p < 0.10

Table 17: Extensive Margin, Probit Regressions, by Age Cohort.

WTP LTCI, Yes	Age ≤ 34	34 < Age < 65	65 ≤ Age
G_1	-0.253**	0.141*	0.394***
	(0.119)	(0.073)	(0.152)
T_1	0.169	-0.259***	-0.157
	(0.135)	(0.082)	(0.180)
Area FE	Yes	Yes	Yes
Observations	924	2,668	589

Robust standard errors in parentheses. *** p < 0.01, ** p < 0.05, * p < 0.10

Table 18: Extensive Margin, Probit Regressions, by Education.

WTP LTCI, Yes	Primary	Secondary	Tertiary
G_1	0.121	0.132*	-0.049
	(0.118)	(0.080)	(0.114)
T_1	-0.213	-0.148	-0.051
	(0.130)	(0.092)	(0.133)
Area FE	Yes	Yes	Yes
Observations	981	2,106	1,094

Robust standard errors in parentheses. *** p < 0.01, ** p < 0.05, * p < 0.10

Table 19: Extensive Margin, Probit Regressions, by Health Insurance Status.

WTP LTCI, Yes	No Health Insurance	Health Insurance
G_1	0.083	0.047
	(0.065)	(0.131)
T_1	-0.168**	0.079
	(0.073)	(0.159)
Area FE	Yes	Yes
Observations	3,079	1,102

Robust standard errors in parentheses. *** p < 0.01, ** p < 0.05, * p < 0.10

Appendix

Experimental questions We randomly divide the sample G into two groups, G_1 and G_2. Group G_1 receives the first informational treatment.

Group G_2 receives no information at this stage. After the treatment, both groups respond to the following questions.

Q 1: Do you know someone who is not self-sufficient as described above?

a. Yes
b. No

Q 2: Are you familiar with Long-Term Care insurance (LTCI)?

a. Yes
b. No

Now, split G_1 into two subgroups, T_1 and T_2. Give group T_1 the second informational treatment. After the treatment, ask all groups the following questions.

Q 3: Although the risk is mostly concentrated in old age, some people decide to protect themselves from the risk of non-self-sufficiency from a young age. In your case (for yourself or your spouse/partner), how do you plan to deal with this eventuality?

a. I will use my savings
b. The State will help me
c. My family will help me
d. I plan to take out specific insurance (Long-Term Care)
e. I am already covered through my employer
f. I am privately insured
g. At the moment, it's not a problem that concerns me, I'm not interested in dealing with this possibility
h. I don't know, I've never thought about it

If the answer to **Q 3** is "I am privately insured", ask the following.

Q 3BIS How much do you pay (even approximately) for this coverage?

Cost: €___

Q 4: Imagine you are offered insurance (in the form of a policy or a Long-Term Care fund) that, in the event you find yourself in a condition of non-self-sufficiency, would provide you with a lifetime payment of €1,500 per month (in addition to your salary or pension and any other benefits you may receive). How much would you be willing to pay per month for insurance of this kind?

a. 10
b. 25
c. 50
d. 75
e. 100
f. I don't know
g. I am not willing to pay for this insurance

If the answer to **Q 4** is either "I am not willing to pay for this insurance", ask the following.

Q 4BIS Why are you not willing to pay for this insurance?

a. I don't think I am at risk
b. I don't have sufficient income
c. I don't understand how this type of insurance works
d. I don't trust this type of insurance
e. Other (specify)

Q 5: How old are your parents? (Please indicate the age of the older parent)

Age: ____

If the answer to **Q 5** is *Age* > 60, ask the following.

Q 5BIS Would you be willing to purchase a Long-Term Care policy under the same conditions for one or both of your parents?

a. Yes
b. No