primary insomnia and the relative risk of the health consequence in persons with versus without insomnia. Based on published sources, we estimated the prevalence of chronic primary insomnia to be 2.3% and relative risks to be as follows: car crashes, 2.5; work accidents, 1.5; home/public accidents, 2.5; alcohol abuse, 2.3; illicit drug abuse, 1.9; nicotine dependency, 2.4; and depression, 5.4. RESULTS: Total annual societal cost of chronic primary insomnia in the U.S. was estimated to be US$24.6 billion in 2003. Depression accounted for the largest share of the cost burden (34%), followed by alcohol abuse (25%), nicotine dependency (20%), drug abuse (14%), work loss (6%), accidental injuries (2%), and prescription insomnia medications (1%). Sensitivity analysis indicated the findings were most sensitive to the prevalence of chronic primary insomnia and the relative risk of illicit drug abuse. CONCLUSIONS: The economic burden of chronic primary insomnia is substantial. Reducing the severity and prevalence of chronic primary insomnia may yield considerable economic benefits.

**OBJECTIVES:** Although studies have explored the utilization of healthcare services in patients with restless leg syndrome (RLS), expenditure data are not available. This study assesses the incremental economic burden of illness with RLS. METHODS: A retrospective claims database analysis was conducted using Medstat's MarketScan Commercial Claims and Encounters database from 1999 through 2003. Patients were identified having ≥ 1 RLS diagnosis (ICD-9 333.99) with the earliest claim as the index event. Inclusion criteria required continuous enrollment 6 months pre- and 12 months post-index event. Patients were excluded if they were identified as having Parkinson’s disease, post-traumatic neurosurgery, or psychiatric conditions (other than depression and insomnia); or if they had a drug claim in the pre-index period for levodopa, dopamine agonists, opioids, anxiolytics, amantadine or clonidine. A control group without a diagnosis for RLS and similar inclusion/exclusion criteria as the RLS group was selected using a 1:1 propensity score match. Post-index outcomes included health care utilization and expenditures (2003 dollars), along with multivariate analysis used to determine the incremental economic burden associated with RLS. RESULTS: The RLS group consisted of 2319 patients with an average age of 49.8 years and was 64% female. In the post-index period, RLS patients had higher total expenditures than controls ($8843 vs $4378), with highest costs from outpatient services ($4549 vs $2144, respectively). In the multivariate analysis, the incremental difference in overall expenditures between the RLS cohort ($7257) and controls ($4809) was $2448 ($p < 0.001). CONCLUSIONS: Expenditures for RLS treated patients are significantly higher when compared to a matched, control cohort of patients, with the highest costs coming from outpatient services. More research is warranted to identify if there are ways to decrease these additional costs while maintaining or improving treatment of patients with RLS.

**OBJECTIVES:** To estimate the direct healthcare cost burden of migraine in a large commercially insured United States (US) population. METHODS: The data source for this study was the MEDSTAT MarketScan database, comprised of medical, pharmaceutical, and enrollment information on employees for 52 employer groups for the calendar year 2004. Subjects with a diagnosis of migraine or use of a migraine-specific abortive drug were identified as the migraine cohort. A random sample of patients without migraine was propensity score matched, based on demographic characteristics and comorbidity index, to the migraine cohort to yield a matched control group. Expenditures between migraine and matched control cohorts were compared to derive the burden of illness attributable to migraine. RESULTS: The analyses included 215,209 subjects in the migraine cohort, and equal number of subjects in the control group. The mean age was 41 (SD = 13.3), and 82% were female. After matching, the cohorts were similar with respect to age, gender, geographic region, urban residence, insurance type, the number of psychiatric diagnostic groups and Charlson comorbidity index. The migraine cohort incurred significantly higher expenditure than the control cohort in all categories (prescriptions, outpatient, ER, and inpatient). Total health care expenditures were $2571 per patient per year (PPPY) higher in the migraine group ($7007 versus $4436 PPPY in the control group; p < 0.001). CONCLUSIONS: The migraine cohort was associated with significantly higher total health care expenditures compared to a matched control, based on recent data from a large sample of commercially insured individuals. This data suggest that US employers are bearing a considerable direct cost burden as a consequence of migraine.